TIP 15: Treatment for HIV-Infected Alcohol and Other Drug Abusers: Treatment Improvement Protocol (TIP) Series 15

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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human

Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then communicated to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Chair (or Co-Chairs) for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment used in public and private programs recognized for their provision of high quality and innovative treatment.

This TIP *Treatment for HIV-Infected Alcohol and Drug Abusers* presents guidelines for creating a comprehensive, integrated system of care for HIV-infected AOD abusers. The guidelines identify a spectrum of core services and treatment approaches that ideally should be available to this population regardless of the setting in which care is provided. Prevention and treatment of AOD abuse and HIV disease require a multidisciplinary approach that relies on the strengths of a variety of providers and treatment settings. For service providers who may not be familiar with the treatment system, the TIP provides an overview of AOD treatment settings. An extensive chapter is included, primarily for physicians, nurses, and other medical care providers, on the scope of medical care needed by HIV-infected persons. Another chapter describes the mental health and other counseling needs of HIV-infected substance abusers and provides guidelines for meeting the needs effectively. A chapter on social service needs addresses issues of housing, family support, and outreach services. The TIP describes linkages and collaborations that AOD programs must form with community service providers to provide an array of services. Finally a separate chapter addresses key legal issues, such as confidentiality, encountered in providing services to HIV-infected persons.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) 800-729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (OD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

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TIP 15: Chapter 1 - The HIV Challenge to AOD Treatment[1]

Alcohol and other drug (AOD) abuse and human immunodeficiency virus (HIV) infection can be viewed as "twin" epidemics. They often coexist in the same individual, who is at risk from exposure to other infectious diseases such as tuberculosis (TB) and sexually transmitted diseases (STDs) as well. The capacity of AOD abuse treatment programs to address these multiple health problems has expanded greatly in recent years, but there remains a need for comprehensive guidelines for screening, treatment, and referral of AOD patients with HIV and other infectious diseases.

Most AOD abusers with HIV infection or AIDS are injecting drug users (IDUs) in inner cities. They are poor, hard to reach through traditional public health methods, and in need of a spectrum of services. Collaborative, efficient approaches must be developed among AOD specialists, public health officials, mental health specialists, and private treatment providers to prevent further spread of disease and to assure delivery of high-quality care to infected individuals. In the treatment of patients with HIV disease, members of different disciplines must put aside all issues of turf and responsibility.

Overcoming the historical fragmentation of services among different disciplines and institutions is an enormous challenge. A further challenge involves overcoming misunderstanding and lack of communication based on differences in ethnicity, culture, economic status, sexual orientation, and lifestyle. The recommendations and guidelines in this Treatment Improvement Protocol (TIP) represent an approach to the creation of a comprehensive, integrated system of care for HIV-infected AOD abusers.

Role of the Consensus Panel

The purpose of the Center for Substance Abuse Treatment consensus panel that met in New York City in January 1993 was to develop a basic set of recommendations and guidelines for quality care for AOD abusers in treatment who are infected with HIV. These guidelines identify a

spectrum of core services and treatment approaches that ideally should be available to all HIV-infected AOD abusers, regardless of the setting in which they receive care. The panel also addressed screening and referral issues for mental health, social, and other services needed to ensure the delivery of a comprehensive range of care to this patient population.

There are various audiences for this TIP, and different chapters are targeted to some of them individually. Nevertheless, the entire document should be of interest to any persons interested in improving HIV care for people who have alcohol and other drug problems. Prevention and treatment of AOD abuse and HIV disease require a multi-disciplinary approach that relies on the strengths of a variety of providers and treatment settings to provide a comprehensive range of effective services. It is unrealistic to expect any single treatment provider to be competent in all areas of care; likewise, it is unrealistic to expect any single treatment facility, whether a drug treatment center or a primary care clinic, to possess the full range of expertise required to meet all of the medical, mental health, and social service needs of this population. Thus, coordination and collaboration between health, mental health, and social service agencies and providers at all levels is imperative.

Prevention and treatment of AOD abuse and HIV disease require a multidisciplinary approach that relies on the strengths of a variety of providers and treatment settings to provide a comprehensive range of effective services.

The recommendations in this TIP identify a spectrum of treatment approaches and services that are essential to provide to HIV-infected individuals in treatment for AOD abuse. Guidelines are provided for bringing about linkages among the many separate agencies that make up the treatment system; such interagency collaboration is now required for States to receive Federal substance abuse block grants. See Appendix B for a summary of the 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule (45 C.F.R. Part 96).

Chemical dependence and HIV infection are both chronic diseases with remissions and exacerbations. "A framework of providing a spectrum of services for long-term healthcare is needed when conceptualizing the treatment of either or both illnesses" (Karan, 1990). Treatment

may include both pharmacologic therapies and nonpharmacologic modalities such as individual counseling, group therapy, support groups, family therapy, cognitive and behavioral therapies, psychotherapy, and psychodrama. Nonclinical activities such as attendance at Alcoholics and Narcotics Anonymous meetings, spiritual development, stress management, and relaxation are also important elements of successful treatment.

Epidemiology of HIV Infection in AOD Abusers

Definitive data on the prevalence of HIV infection among AOD abusers are scarce. Available data may not be generalizable because they are usually derived from different, often small, populations. However, it is clear from the available data that chemically dependent persons are at high risk for acquiring HIV infection. Among chemically dependent persons, the highest seropositivity—evidence of HIV in the blood -- for HIV infection or AIDS is among IDUs, and noninjecting AOD users put themselves at risk when they use unsafe sex practices. Fear and/or denial may cause noninjecting AOD users to inappropriately consider themselves excluded from risk groups.

There are an estimated 1.2 million IDUs in the United States. According to the U.S. Centers for Disease Control and Prevention (CDC), 34 percent of the CDC-defined AIDS cases diagnosed in the United States as of June 30, 1993, were linked to injection drug use. Twenty-three percent were heterosexual IDUs, 6 percent were homosexual or bisexual IDUs, 3 percent were heterosexual partners of IDUs, and 1 percent were perinatal cases where the mother either was an IDU or had been the sex partner of an IDU (CDC, 1993b). Specific high-risk behavior, such as injecting drugs in a shooting gallery, can be identified in these groups.

The seroprevalence of HIV infection among IDUs varies from region to region in the United States.

Levels of HIV infection have been highest in the Northeast, the middle Atlantic States and, to a slightly lesser extent, the Southeast, with generally decreasing levels in the Midwest, Southwest, and Northwest. Since early in the HIV epidemic, the Northeast (in particular New York City) has

tended to have the highest seroprevalence rates among IDUs. One recent study found that the HIV seroprevalence rate among IDUs in New York remained stable at slightly more than 50 percent from 1984 through 1992 (Des Jarlais et al., 1994b).

Among drug injectors, specific practices such as needle sharing and injection in shooting galleries have been clearly identified as important HIV risk behaviors (Schoenbaum et al., 1989). One study, involving heterosexual IUDs who were enrolled in public methadone treatment programs in San Francisco in 1986 and 1987 before the advent of crack cocaine, showed that persons who injected cocaine had a higher risk of being HIV seropositive than those who did not inject cocaine (Chaisson et al., 1989). This increased risk can probably be associated with frequency of injections resulting from the short-term effect and highly addictive nature of cocaine. In addition, a subgroup of cocaine users may be more likely to engage in high-risk sexual behavior and to exchange sex for drugs (Weiss, 1989).

Among drug injectors, specific practices such as needle sharing and injection in shooting galleries have been clearly identified as important HIV risk behaviors.

The risk of HIV infection is lower among AOD users who do not inject. However, one study found a substantial prevalence of HIV infection among heterosexual patients in San Francisco alcohol treatment programs; much of this prevalence was not associated with injection drug use. The overall rate of HIV seroprevalence in this population was 5 percent. Unsafe sexual practices were common in the study population (Avins et al., 1994). Alcohol, like other psychoactive substances, may have a disinhibiting effect on sexual behavior.

African American and Hispanic communities are being extremely hard hit by the twin epidemics. According to the National Commission on AIDS, 45 percent of cases of HIV infection in AOD abusers occurred among African Americans and 26 percent among Hispanics in 1991. By comparison, African Americans and Hispanics accounted for 28 and 16 percent, respectively, of AIDS cases not involving AOD abuse.

Recognition of the crucial interrelationship between substance abuse and HIV infection has led to the establishment of needle exchange programs (NEPs) in some parts of the country, particularly large population centers with high rates of both substance abuse and HIV infection. NEPs are programs in which drug injectors can obtain sterile needles and syringes and return used injecting equipment (Donoghoe et al., 1992). Although much controversy surrounds the practices of NEPs, a study sponsored by the CDC concluded in 1993 that NEPs may prevent HIV infections and that they do not appear to change overall community levels of injection drug use (Lurie et al., 1993). (See Appendix C, on the elements of a needle exchange program.)

Obstacles to the Provision of Integrated Care to HIV-Infected AOD Abusers

Staff of most AOD abuse treatment programs have faced the need to provide medical treatment of HIV infection and AIDS to patients in the populations they serve. Treatment options in an individual case will depend on factors such as the availability of hospital and outpatient treatment for HIV infection and nonhospital residential facilities and halfway houses for those who are medically stable but need structure and support away from their home environments. Intensive outpatient counseling is often needed, along with home visits and nursing home and hospice care.

However, the life circumstances of many HIV-infected AOD abusers make continuity of care difficult or impossible to achieve. AOD abusers often suffer from poor health and nutrition and inadequate living conditions as well as a stressful lifestyle and lack of self-care. They may be very ill by the time they seek treatment. Individuals who live in poverty, in homeless shelters, on the street, or in correctional facilities generally lack access to good medical care, especially good primary care. Without financial resources, they have difficulty following dietary advice. Exposure to TB and STDs is common. A variety of factors, including lifestyle stressors and the effects of drug use, may cause individuals to deny their need for treatment for AOD abuse or HIV and to resist seeking or remaining in treatment.

The most important features of any program providing primary care to HIV-infected patients are minimal barriers to access and a "user friendly" environment. Patients may be deterred from adhering to care if they have to travel a long distance from the referral point to the source of primary care, or if the primary care providers are unfamiliar with or unresponsive to their needs. Language barriers and financial barriers may also exist. Special resources such as transportation and case management services facilitate patient followup of medical care if primary care is delivered offsite.

The most important features of any program providing primary care to HIV-infected patients are minimal barriers to access and a "user friendly" environment.

Systemic barriers to care for HIV-infected AOD abuse patients result from the separate functioning of treatment and prevention programs for AOD abuse and HIV infection, as well as the separation of funding streams for such programs. Consequently, program design and organizational and staffing structures may be inadequate and unidimensional when the demographic profile of the treatment population demands a multidimensional approach.

Multiple service needs are the norm for HIV-infected persons with AOD abuse problems. The AOD abuse treatment program may be able to play a lead role in coordinating care for HIV-infected AOD abusers, given their understanding of the preexisting substance use disorder and the fact that the client may trust and identify more with the AOD abuse treatment program than with other providers. However, AOD treatment programs can only take on such responsibility if they achieve competence in providing case management services. Historically, AOD programs have not provided case management services or have done so poorly. This situation could be improved by redefining the mission of AOD agencies beyond narrow recovery goals and allocating resources to professional social-work or trained counselor/case management staff.

For example, access to mental health and social services will vary depending on whether treatment programs have established linkages with providers of such services. Obtaining housing or homemaker services for a patient with AIDS can be a logistical nightmare for AOD abuse treatment staff. Even when services are finally located, the patient may not have access to

transportation to go to the specified clinic or agency. Other barriers to integrated care include lack of healthcare coverage and a lack of entitlement programs directed at the specific problems of HIV-infected AOD abusers.

Physicians and their staffs often lack the knowledge and experience needed to access social service resources for AIDS or AOD abuse patients. No systems exist to coordinate the provision of medical services with other services outside the medical setting. A further problem is that AOD abuse treatment program staff who lack expertise in HIV issues may fail to refer patients to appropriate HIV treatment services.

Physicians and their staffs often lack the knowledge and experience needed to access social service resources for AIDS or AOD abuse patients. A further problem is that AOD abuse treatment program staff who lack expertise in HIV issues may fail to refer patients to appropriate HIV treatment services.

Philosophical differences between substance abuse treatment and primary healthcare providers may cause confusion for patients and providers alike. For example, a patient's physician may prescribe an antidepressant to treat the patient's severe depression. However, a substance abuse treatment provider, overly concerned about the danger of addiction, may tell the patient not to take the medication even though it is not addictive and it may improve the patient's quality of life.

Whereas a primary care provider may consider any decrease in drug use as an improvement in the patient's health status, a substance abuse provider may view anything short of total abstinence from drug use as a continuation of the patient's addiction. By contrast, the primary care provider, focusing on the need to bring about an improvement in the patient's health status, may fail to appreciate the effect of addiction on the patient's behavior.

For example, an individual may do well in a residential detoxification program, a very structured setting. Outside of that setting, however, and without the support of AOD detoxification staff, the individual may have difficulty staying motivated to continue treatment. If the individual stops

attending Narcotics Anonymous meetings, misses outpatient appointments, and perhaps slips back into drug-seeking behavior, continuity of care suffers.

Preferential Admission to AOD Abuse Treatment for HIV-Infected Patients

When the number of treatment slots is inadequate for the numbers of AOD abusers seeking treatment, programs are faced with deciding whether to give priority to the admission of HIV-positive patients in order to try to stop the use of needles and halt the further spread of HIV. Alternatively, they may decide to admit non-HIV-infected patients in the hope of preventing them from being exposed to the virus through continued needle use. Where preferential admission is practiced, non-HIV-infected AOD abusers may claim to be HIV positive in order to get into highly valued treatment slots, particularly for methadone treatment.

Programs are sometimes faced with deciding whether to give priority to the admission of HIV-positive patients to try to stop their use of needles and halt the further spread of HIV. Or, they may decide to admit non-HIV-infected patients in the hope of preventing them from being exposed to the virus through continued needle use.

Under the 1993 substance abuse block grants interim final rule, programs receiving block grant funds must create a waiting list for patients who are seeking AOD treatment and are at risk for HIV, sexually transmitted diseases, and tuberculosis. Patients on the waiting list are to be given preferential treatment in the following order: pregnant IDUs, other pregnant substance abusers, other IDUs, and all others. People with HIV infection are not specifically identified in the Federal regulations as a group mandated to receive preferential treatment.

The appropriateness of a preferential admission policy for HIV-infected AOD abuse patients will depend upon the HIV seroprevalence rate among the population served by a treatment program. Programs should consult with local health departments and other community agencies when deciding whether to adopt a preferential admissions policy.

Cultural Competence of Providers

AOD abuse treatment staff need to be sensitive to the culture in which their patients live. However, cultural sensitivity by itself is not enough. Staff also must be competent in providing services to people from cultures other than their own. Cultural sensitivity and competence are crucial to the recruitment and retention of HIV-infected AOD abuse patients in treatment. Acquiring this competence may require staff to participate in training courses that focus on developing skills in cultural competence. Appendix D provides a Cultural Proficiency Questionnaire disseminated by the San Francisco Department of Public Health AIDS Office. It is a management tool to help agencies determine the degree to which their staffs and services are credible to members of the various communities to be served.

Cultural sensitivity and competence are crucial to the recruitment and retention of HIV-infected AOD abuse patients in treatment.

Staff must be able to provide services that are acceptable within the context of the culture of the persons they serve. Treatment staff who understand how patients define and regard sexual orientation, family, community, gender, and religion or spirituality are best able to develop positive relationships with patients and help empower them to overcome high-risk behavior. The treatment staff's understanding of and sensitivity to issues related to sexual orientation are very important. Staff should be aware of the pressures experienced by gay, lesbian, and bisexual patients in the employment setting and in the local community. Some treatment staff may have limited ability to deal with matters of sexual orientation, and this limitation can be a barrier to access to treatment for gay, lesbian, or bisexual patients.

The fact that many AOD treatment providers are themselves recovering from AOD abuse and are members of the ethnic and cultural communities they serve is an important element of cultural competence. Training and affirmative action hiring can help to ensure that therapists, counselors, and group leaders are sensitive to patients' culture, ethnicity, and language or language style. Cultural compatibility between group leaders and patients facilitates group interaction and discussion of sensitive issues—effective counseling about HIV risk reduction must

take account of both drug-using and sexual behaviors. Patients may have significant socioeconomic problems related to housing, employment, and legal and entitlement issues; these problems can be identified and addressed in culturally competent programs. It is also important for treatment staff to be prepared to provide appropriate treatment to women. Alcohol is often the link in transmission of HIV disease to women, since it can lead to sexual disinhibition. A similar effect on sexual feelings is associated with the use of cocaine and crack cocaine.

Care providers need an understanding of the nature and role of the family in minority cultures. This understanding includes acceptance of the family as defined by the patient. Sometimes, the patient's family may include or consist entirely of persons who are not related to the patient by blood or marriage. The notion and understanding of family take on added importance in view of the fact that rates of heterosexual and perinatal transmission of HIV are highest in African American and Hispanic communities. Thus, the families with whom AOD treatment staff come into contact are likely to be of low socioeconomic status, particularly in urban areas. Such families may be headed by women, often very young women with children. An extended family may be in place that assists with the provision of shelter, childcare, and emotional support. Care providers should seek to involve family members appropriately in information sharing and in education about HIV and AOD abuse.

Care providers should understand and accept how the patient defines his or her family. Sometimes, the patient's family may include or consist entirely of persons who are not related to the patient by blood or marriage.

Appropriate utilization of AOD and other health services can be increased when services are sited in affected communities and when local resources such as clergy and traditional healers are involved in activities such as outreach, advocacy, and the promotion of healthy lifestyles. Involving patients in program evaluation through the use of consumer satisfaction surveys can help to ensure that services are meeting patients' self-identified needs in a culturally appropriate way.

Finally, an understanding of the place of spirituality and religion in patients' communities is important. Leaders and members of churches and other sources of spiritual counseling and support can be important allies in bringing patients into treatment and gaining their compliance with treatment regimens.

Conclusion

To provide comprehensive, coordinated care to HIV-infected AOD abusers, treatment programs must assess their existing resources and identify gaps. Ideally, a multidisciplinary professional team -- including a family physician or an internist, an obstetrician-gynecologist, a psychiatrist, a midlevel practitioner such as a physician's assistant or a nurse practitioner, a nurse, an AOD abuse treatment counselor, and a social worker -- should be available and should work together to meet patients' needs.

Case management at both hospital and community levels is important in achieving coordinated care. Increasingly, staff in AOD abuse treatment programs are finding that they need to conduct case management. Tracking and outreach teams composed of community volunteers are also vital, as is a telephone "hotline" to increase access to care. Developing programs to provide outreach to affected communities, providing home care, and furnishing transportation to health and AOD services can promote AOD abstinence and increase compliance with treatment regimens.

Substance abuse treatment, particularly opioid substitution therapy, of HIV-infected AOD abusers has been shown to be effective in reducing the spread of HIV (Ball et al., 1988; Hartel et al., 1988). In addition, addiction treatment can improve HIV-infected AOD abusers' quality of life by increasing their self-esteem, improving their sense of well-being, and helping them develop spiritually. Treatment can help them gain strength in making peace with themselves and their families and in determining how they want to spend the remaining portion of their lives.

Substance abuse treatment of HIV-infected AOD abusers has been shown to be effective in reducing the spread of HIV. In addition, addiction treatment can improve HIV-infected AOD

abusers' quality of life by increasing their self-esteem, improving their sense of well-being, and helping them develop spiritually.

Contents of This TIP

While developed primarily to assist providers in AOD treatment facilities, this TIP may also be useful to providers in other settings, such as public health clinics, in improving the range and quality of services provided to AOD abusers. Staff of State agencies who are responsible for planning and administering AOD and HIV treatment programs may also find the TIP helpful in developing their own guidelines and providing technical assistance and quality assurance services.

Many service providers in other programs are confused by the profusion of different types and settings of care for AOD abuse. Chapter 2 *Overview of AOD Treatment Services* provides them with a brief description of the types, settings, levels, and intensities of treatment provided in each type of program.

Chapter 3 *Primary Medical Care for HIV-Infected AOD Abuse Patients* is primarily for physicians, nurses, and others responsible for the provision of medical care, but others may find it helps them understand the scope of medical care needed by patients. The standards of medical care and infection control that should be met by programs providing medical services are clearly spelled out. Also discussed are program and policy issues and issues in engaging HIV-infected AOD patients in medical care.

Chapter 4 *Mental Health and Counseling Needs of HIV-Infected AOD Abusers* describes the counseling needs of HIV-infected AOD abusers and provides guidelines for meeting them effectively. It also provides important guidelines for treatment as well as referral. This chapter is very important to counselors who must be familiar with both AOD-induced and HIV-induced psychiatric symptoms. Programs without the ability to assess and treat mental illness must have the capacity to make appropriate referrals.

Populations already having complex social service needs because of AOD abuse have additional needs as a result of HIV infection and disease. These populations frequently do not want to receive services from any agency but the AOD program. This dilemma is addressed in Chapter 5 *Social Services for HIV-Infected AOD Abusers.* Attention is focused specifically on the provision of case management and housing, family support, and outreach services.

Chapter 6 *Linkages and Services Integration: Policy and Implementation* focuses on the linkages and collaboration with community service providers needed by AOD programs to meet patients' needs effectively. These needs include the medical, mental health, and social service needs outlined in previous chapters. This chapter is very important for AOD programs that do not have the resources to provide all needed services.

Chapter 7 addresses legal issues in AOD and HIV treatment as they are related to treatment, confidentiality, HIV counseling, and tuberculosis testing. *Key Legal Issues in HIV/AIDS and AOD Abuse Treatment* deals with issues that arise when treating patients who are HIV-positive, perceived to be HIV-infected, or diagnosed with AIDS. Also covered are legal requirements for dealing with infectious diseases frequently associated with HIV disease.

Appendix A is a list of references cited in the TIP. Appendix B contains a brief summary of the 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule. The public health impact of needle exchange programs and the elements of such programs are described in Appendix C. A questionnaire used by the San Francisco Department of Public Health AIDS Office to help programs assess their cultural proficiency is included in Appendix D.

Information about the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (the CARE Act) is provided in Appendix E. Appendix F contains an instrument used by the Opiate Treatment Outpatient Program at San Francisco General Hospital to assess a client's level of functioning in order to provide an appropriate level of care. Appendix G provides a list of national AIDS/HIV organizations and hotlines. A sample memorandum of understanding, used to establish interagency relationships, is presented in Appendix H. The names and affiliations of members of the Federal Resource Panel who guided the planning of this document are included in Appendix I.

Appendix J lists names and affiliations of experts who reviewed the first draft of the TIP and provided valuable comments.

Endnote

Footnotes

1

. This chapter was written for the TIP by Coralee Hoffman and Carolyn Davis.

TIP 15: Chapter 2—Overview of AOD Treatment Services[1]

What is alcohol and other drug (AOD) addiction? It is a chronic, progressive, pathologic process that typically includes compulsion to use or reuse AODs, loss of control over AOD use, and continued AOD use despite adverse consequences.

Exhibit 2-1 DSM-IV Diagnostic Criteria For Substance

(more...)

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994) enumerates diagnostic criteria for substance dependence -- the term used by the American Psychiatric Association to describe AOD addiction (see Exhibit 2-1). According to the DSM-IV, a diagnosis of substance dependence requires the presence of three or more of these criteria at any time in the same 12-month period. Tolerance, physiological dependence, and withdrawal are not necessary to establish a diagnosis of AOD addiction.

Addiction is a biopsychosocial process. The onset, progression, type, and severity of addiction are influenced by biological, psychological, and social factors; in turn, addiction has a profound impact upon the individual's biological, psychological, and social functioning. For these reasons, AOD treatment should be biopsychosocial in nature. In a biopsychosocial orientation, the focus of treatment will shift from one area to another depending upon the patient's status and treatment needs. For example, the early stages of AOD treatment may focus on pharmacologic management of medical and psychiatric crises. As treatment progresses and these crises fade, other biopsychosocial factors can be addressed in such activities as individual or family counseling.

AOD Treatment Settings

AOD addiction treatment was traditionally designed on a standardized model that began with inpatient hospitalization for detoxification (medically supervised withdrawal) and rehabilitation for 30, 45, or 60 days. This model was adopted by healthcare facilities because insurance companies paid for care, using criteria based on this model. Outpatient AOD treatment -- lasting from several months to 1 or more years -- traditionally followed the inpatient hospitalization.

Today, AOD treatment often begins with an assessment of the level of treatment intensity required to meet an individual patient's needs, which may or may not include hospitalization. As patients successfully meet their treatment goals, they proceed to less intensive levels of care.

There are three primary levels of care: inpatient, intensive outpatient, and outpatient treatment. **Inpatient** treatment includes short-term and long-term hospitalization. **Intensive outpatient** treatment includes partial hospitalization, day programs, and evening programs. **Outpatient** treatment generally involves a set number of hours weekly. All three levels of care include such activities as group counseling or individual therapy; education; attention to medical, mental health, or social issues; and participation in 12-step programs.

AOD treatment and recovery services can be delivered in a variety of residential settings, including intensely supervised therapeutic communities; supervised group homes; and unsupervised, drug-free halfway houses.

AOD treatment options are greatly influenced by financial considerations. Increasingly, insurance payers and managed-care providers pay for AOD and psychiatric treatment on a day-by-day basis, with an emphasis on minimizing both the duration and the intensity of treatment.

The major source of funding for publicly funded AOD addiction treatment is the substance abuse State block grant, which is administered by the Center for Substance Abuse Treatment (CSAT), an agency of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

Increasingly, insurance payers and managed-care providers pay for AOD and psychiatric treatment on a day-by-day basis, with an emphasis on minimizing both the duration and the intensity of treatment.

Through the years, separate branches of Federal and State governments have provided distinct funding for alcohol treatment, drug abuse treatment, and mental health treatment. As a result, several types of publicly funded programs provide AOD abuse treatment in dissimilar settings for different types of patients, often using different treatment approaches and philosophies. Ideally, such a collection of public-sector programs would create a comprehensive treatment network capable of addressing detoxification, long-term treatment, and relapse prevention. In practice, although an extensive treatment network exists in many geographic areas, treatment services are fragmented and incomplete; in some areas services are inadequate.

Variants of treatment programs include special gender-specific and culture-specific programs, as well as programs for underserved groups such as single mothers, adolescents, families, gay men and lesbians, and people infected with the human immuno-deficiency virus (HIV). Depending on local resources, there may or may not be an extensive continuum of care in the public sector.

Overall, treatment settings differ with respect to duration, intensity, and setting. Treatment for an individual may involve multiple settings, either serially or simultaneously.

Outreach and prevention. The structure of medical services is such that people are generally required to seek medical care in order to receive it. Such an approach excludes people who are not seeking treatment, have poor insight about their AOD use, or are unaware of treatment resources. Many of these people may be at risk of contracting HIV infection as a result of the sexual disinhibition that accompanies AOD abuse. Community-based outreach workers can provide personal contact between the medical establishment and people requiring education, intervention, and treatment.

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Some models of outreach and prevention focus directly on AOD prevention, intervention, and treatment, often in unconventional sites, such as inner-city hotels, recreational areas, and the street. Needle exchange programs, which provide clean needles and syringes to injection drug users in exchange for used ones, employ a harm reduction approach to reducing the risk of HIV infection from injection drug use. Most needle exchange programs also supply condoms and provide bleach for syringe disinfection; most programs selectively refer clients to AOD abuse treatment Lurie et al., 1993). (See Appendix C for information about needle exchange programs.)

Levels of Care

Outpatient treatment traditionally involves only a few hours of treatment per week; it is the least intensive and restrictive level of care in addiction treatment. This level of treatment is most appropriate for people who are employed, have a stable and supportive social and family environment, recognize that their AOD use is a problem, and desire help for the problem. Outpatient programs provide no living facilities and usually have little medical supervision, although most of these "social model" programs are affiliated with one or more medical facilities

and personnel. A variety of outpatient treatment models exist. They usually provide counseling, peer support, and social services referrals. Most incorporate the principles of abstinence-based 12-step programs such as Alcoholics Anonymous.

Intensive outpatient treatment (IOT) programs generally provide a few hours of treatment each day, often including weekends. For example, programs may provide 2 to 8 hours of treatment Monday through Friday and perhaps 2 to 8 hours each weekend. These programs may last 6 to 12 weeks or longer. Some programs offer treatment sessions in the evening and on weekends to allow people to continue working while participating in treatment.

As a higher level of care than outpatient treatment, IOT offers more structure and more hours of treatment per week. It can provide multiple treatment components in the same setting and allows for increased bonding among peers in treatment through group interaction. This bonding may facilitate a drug-free social network of friends who have sobriety as a central focus. The most common models of IOT include day treatment programs (partial hospitalization), evening treatment programs, and weekend treatment programs. (Another Treatment Improvement Protocol [TIP] in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse,* provides an extensive discussion to one approach to providing this level of care.)

Partial hospitalization or day treatment is a form of intensive outpatient treatment that lasts 5 to 8 hours per day, from 5 to 7 days per week. Partial hospitalization provides treatment similar to that found in the daytime portion of an inpatient program. It may combine partial hospitalization and dedicated residential living for patients, making possible intensive daytime treatment and regulated evening activities.

Evening treatment programs typically provide 2 or more hours of treatment several evenings per week. **Weekend treatment programs** typically provide 5 or more hours of treatment on Saturday and Sunday. In practice, IOT programs often include some combination of daytime, evening, and weekend treatment.

Inpatient treatment is the most intensive level of care for AOD abuse. It generally includes medical, psychiatric, and nursing care. Inpatient treatment is particularly valuable for medical and psychiatric evaluations, medical management of detoxification, and management of medical problems (related or unrelated to the addiction), as well as management of psychiatric crises. The enhanced accessibility of medical and psychiatric care in inpatient treatment is particularly valuable for the AOD treatment patient who needs medical care related to HIV infection and infectious diseases, such as the tuberculosis or sexually transmitted diseases that occur at a high rate among HIV-infected AOD abusers.

The enhanced accessibility of medical and psychiatric care in inpatient treatment is particularly valuable for the AOD treatment patient who needs medical care related to HIV infection and infectious diseases, such as tuberculosis or sexually transmitted diseases that occur at a high rate among HIV-infected AOD abusers.

Residential treatment programs consist of a spectrum of live-in settings. The treatment philosophy may be an abstinence-based medical model with a 12-step program orientation. These programs are often approved and accredited by the Joint Commission on Accreditation of Health Care Organizations. Occasionally, these programs are hospital based, but most residential programs are freestanding. Treatment may last from 1 week (detoxification) to 28 days (rehabilitation) or even more. Often when treatment in this setting is completed, patients are referred to an outpatient program.

Social model residential treatment programs and **halfway houses** are other models of residential addiction treatment. The residence used exclusively for patients may be a house or apartment, often with a resident manager. In residential treatment, patients are often responsible for the normal activities of daily living. Programs are often designed so that patients obtain and prepare their own meals, do their own laundry, keep the residence clean, and set and observe house rules.

Therapeutic communities are residential treatment systems in which adults and older adolescents with long and severe histories of substance abuse are treated in a peer-based

milieu. A behavioral relearning process that incorporates both positive reinforcement and negative sanctions is the principal treatment modality. Residents themselves provide some aspects of treatment as a requirement before they can leave the program. Treatment typically lasts between 18 and 36 months. Most therapeutic communities operate according to a rigid set of rules and norms. Health services are not always provided onsite.

Special treatment settings provide for addiction treatment at nontraditional sites, such as prisons and community-based programs for offenders on probation or parole, housing projects, homeless shelters, runaway shelters, community-based organizations, churches, and group homes. Some hospital-based HIV/AIDS treatment programs also provide a range of AOD treatment services.

Opioid Substitution Therapy

Most injecting drug users (IDUs) are addicted to opioids. Opioid substitution therapy is the most common treatment for opioid addiction, especially in cities with high HIV seroprevalence. Formerly called methadone maintenance treatment, this approach now may include the use of levo-alpha-acetyl-methadol (LAAM), which is similar to methadone but has longer acting effects. Three other TIPs in this series provide a detailed overview of opioid substitution therapy: *State Methadone Treatment Guidelines, Matching Treatment to Patient Needs in Opioid Substitution Therapy, and LAAM in the Treatment of Opiate Addiction.*

Opioid substitution therapy has been proposed as the preferred method of treatment for the HIV-infected opioid user (Cooper, 1989; Ball et al., 1988; Batki, 1988) because it frequently involves daily attendance at a clinic that may offer access to medical care, psychiatric consultation and treatment, neuropsychological evaluation, and social services. Studies have demonstrated that opioid substitution therapy is associated with a reduced risk of contracting HIV and may prevent infection of those patients not yet exposed to the virus (Lowinson et al., 1992).

The principal use of opioid substitutes in the treatment of opioid addiction is in opioid substitution combined with either detoxification or maintenance. These modalities are found in both public and private settings.

Opioid detoxification (medically supervised withdrawal). The primary medical goal of opioid detoxification is to manage the acute opioid withdrawal syndrome. The pharmacologic objectives of opioid detoxification using methadone are substitution of the opioid of choice with pharmacologically equivalent doses of methadone, a period of pharmacologic stabilization, and incremental reduction of methadone.

Federal regulations describe two types of medically supervised withdrawal from opioids: short-term (up to 30 days) and long-term (30 to 180 days). (Regulations do not permit use of LAAM for either short- or long-term detoxification.) Assuming no consumption of opioids beyond the administered methadone, short-term opioid detoxification ends in an opioid-free state 30 days or less from commencement of opioid substitution therapy (often 21 days or less). Long-term opioid detoxification is currently the subject of demonstration projects and research efforts.

Opioid substitution therapy has been proposed as the preferred method of treatment for the HIV-infected opioid user because it frequently involves daily attendance at a clinic that may offer access to medical care, psychiatric consultation and treatment, neuropsychological evaluation, and social services. Studies have demonstrated that opioid substitution therapy is associated with a reduced risk of contracting HIV and may prevent infection of those patients not yet exposed to the virus.

Opioid maintenance therapy. The primary medical goal of opioid maintenance is to substitute methadone or LAAM for heroin or other opioids. The primary pharmacologic objectives are substitution of the opioid of choice with equivalent doses of methadone or LAAM and continued administration of methadone or LAAM for a prolonged period measured in months or years. The administration of methadone or LAAM to treat opioid addiction for more than 30 days is considered maintenance.

Outpatient opioid treatment. Both detoxification and maintenance can occur in an outpatient setting. Outpatient treatment typically involves daily or near-daily visits by the patient to a dispensing clinic. Ideally, methadone or LAAM treatment is accompanied by supportive psychosocial services such as medical and psychiatric treatment, AOD counseling, and vocational counseling. In practice, there is great variability among programs: some provide minimal psychosocial support services while others provide a high level of psychosocial services.

Intensive outpatient treatment. This is an ideal level of care for patients needing detoxification or methadone/LAAM maintenance because intensive outpatient treatment programs can provide several types of psychosocial services. Studies show that opioid substitution therapy programs that provide medical and psychiatric care, social work assistance, family therapy, and employment counseling promote several positive outcomes, including improvements with regard to AOD use, criminal involvement, family relations, the need for emergency services, psychiatric status, and employment (McLellan et al., 1993).

Studies show that opioid substitution therapy programs that provide medical and psychiatric care, social work assistance, family therapy, and employment counseling promote several positive outcomes, including improvements with regard to AOD use, criminal involvement, family relations, the need for emergency services, psychiatric status, and employment.

Inpatient treatment. Opioid detoxification using methadone is commonly used in inpatient settings where the methadone dosage can be easily controlled and administered. Methadone/LAAM maintenance is uncommon in an inpatient AOD treatment setting. However, it is important that individuals receiving methadone/LAAM maintenance treatment continue to receive these medications while hospitalized for treatment of other medical conditions.

Range of approaches to opioid substitution therapy. Opioid treatment programs differ in the emphasis they place on supportive services and in their orientation toward abstinence. Many programs can be described as employing either the metabolic model or the psychotherapeutic model.

- The **metabolic model** views opioid addiction primarily as a medical problem that can be treated pharmacologically with methadone/LAAM. Within this model, methadone or LAAM is viewed in much the same way as insulin for diabetes or antidepressants for clinical depression. Therefore, abstinence is not a primary treatment goal, and psychosocial services, especially psychotherapy, are viewed as adjuncts to methadone or LAAM (although such views are changing).
- The **psychotherapeutic model** views opioid addiction as a biopsychosocial disorder that requires biopsychosocial treatment, of which methadone/LAAM is one element. In this model, psychosocial services are primary treatment services of at least equal importance to methadone or LAAM. Many programs based on a psychotherapeutic model view maintenance as a vehicle for enhancing psychosocial stabilization, with the goal being abstinence from all AODs.

Sometimes driven by one of the above models, and sometimes driven by other reasons (such as cost), maintenance programs vary greatly with regard to the intensity of services provided.

Minimum opioid maintenance programs generally provide methadone/LAAM and emergency counseling or referral services. One form of minimum maintenance is interim methadone/LAAM maintenance, which is described in Federal regulations 21 (C.F.R.) Part 291. Interim maintenance consists of dispensing methadone/LAAM in combination with education and counseling about HIV, tuberculosis (TB), and needle sharing for people who are on a waiting list for comprehensive methadone/LAAM maintenance treatment services.

Standard opioid maintenance programs generally provide supervised counseling and referral services and use weekly urine screens as the basis for patient management. For example, permitting patients to have "take-home" methadone doses is usually contingent on attendance, negative urine samples, and verifiable employment. (Federal regulations do not permit take-home doses of LAAM.)

Enhanced opioid maintenance programs provide all of the above-mentioned services in addition to medical and psychiatric care, social work assistance, family therapy, and employment counseling. One recent study found that treatment outcomes improved with the provision of enhanced services (McLellan et al., 1993).

Components of AOD Abuse Treatment

Exhibit 2-2 Components of CSAT's Comprehensive AOD

(more...)

Treatment programs for AOD addiction vary in style, purpose, philosophy, and type of patients treated. Certain components of treatment, however, are common to all models of treatment programs. The components of CSAT's model comprehensive AOD treatment program are described in Exhibit 2-2.

Acute AOD Treatment

The treatment of AOD addiction often begins with the management of medical and psychiatric crises. The medical management of toxicity, withdrawal, and other medical sequelae of AOD use is initially important.

The management of toxicity includes emergency medical interventions in response to AOD overdose. Opioid overdose may be treated with an opioid antagonist such as naloxone (Narcan). A benzodiazepine may be administered to quell symptoms of cocaine overdose, such as severe agitation, belligerence, and anxiety.

Management of AOD withdrawal may include substitution therapy with graded reduction of methadone (for opiate addicts) or sedative-hypnotics (for sedative-hypnotic addicts). Medication may also be given for withdrawal symptoms: Clonidine may be given for opioid withdrawal and bromocriptine or amantadine for cocaine withdrawal.

Management of other sequelae of AOD use may include preventing and treating seizure disorder and delirium tremens associated with alcohol abuse, treating infections secondary to needle use, and replacing electrolytes to correct nutritional deficiencies induced by alcohol abuse.

Acute medical problems unrelated to AOD use may also require attention. Since people with AOD problems often ignore general health problems, such problems may be exacerbated. By the time an individual seeks treatment for an AOD problem, other previously ignored health conditions may have progressed to a late stage.

Management of acute psychiatric crises may also be necessary. People who enter AOD treatment often do so in the context of emotional upheaval and family distress. In addition, it is not uncommon for AOD abusers to display psychiatric symptoms such as depression, anxiety, agitation, or disordered thinking. Such patients may require psychiatric assessment and a combination of pharmacologic and psychosocial supportive therapy. (See Chapter 4 for a detailed discussion of the mental health needs of HIV-infected AOD abusers.)

The treatment of AOD addiction often begins with the management of medical and psychiatric crises. The medical management of toxicity, withdrawal, and other medical sequelae of AOD use is initially important.

During and after stabilization of crises, patients are assessed to determine their level of functioning in the following areas: medical, psychiatric, emotional, social, family, vocational, legal, nutritional, and recreational. These evaluations form the basis for individualized treatment plans that guide the treatment process, establish treatment goals, and enable the measurement of treatment success.

Nonacute AOD Treatment

As patients become engaged in treatment and as medical and psychiatric crises lessen in intensity, treatment becomes progressively more psychosocial. Overall AOD abuse treatment goals are met through a variety of treatment components, including education, group processes,

12-step programs, self-help programs, therapy, and counseling. (See Chapter 4 for a discussion of the role of such programs in the treatment of HIV-infected AOD abusers.)

Pharmacologic Adjuncts to AOD Abuse Treatment

The use of methadone for detoxification and methadone and LAAM for maintenance therapy is described above. Two other medications may be used as adjuncts to AOD treatment and recovery: naltrexone (Trexan) and disulfiram (Antabuse).

Although there are fundamental differences between these two medications with regard to pharmacologic activity and purposes, naltrexone and disulfiram share certain clinical similarities. For example, both agents are used to diminish the likelihood of impulsive AOD use. Both are more likely to be prescribed during the continuing-care stage of AOD abuse treatment. Finally, both are considered pharmacologic adjuncts to AOD treatment. That is, used in isolation, they are unlikely to be successful; however, used in the context of a full recovery program, they can provide short-term treatment enhancement.

Disulfiram is an alcohol-sensitizing medication; it produces unpleasant symptoms if the person taking it also drinks alcohol. These symptoms include flushing, coughing and labored breathing, nausea, apprehension, and sometimes vomiting. Disulfiram therapy rests on the theory that the medication helps to provide external controls on drinking until the individual can develop internal controls. The use of disulfiram appears to be most successful for those people who have decided to abstain from alcohol and who need an (often temporary) external aid in carrying out this decision.

Naltrexone (Narcan) is an opioid antagonist, that is, a drug that has the opposite pharmacologic effect of other drugs in its class. It prevents and reverses the pharmacologic activity of opioids. As this TIP was being prepared for publication, the U.S. Food and Drug Administration approved naltrexone for use in the treatment of alcohol addiction. Although this drug has been shown to reduce alcohol craving in some alcohol-dependent persons, more studies are needed before its full value as an adjunct to treatment is known.

Opioids administered during naltrexone therapy produce neither subjective effects such as euphoria nor pharmacologic effects such as analgesia. Naltrexone therapy rests on the theory that if the euphoric, rewarding effects of opioid use are blocked, there is less likelihood of repeated opioid use. Clients who are most likely to benefit from naltrexone therapy include people who have substantial social support for sobriety and who are well motivated for recovery.

AOD Treatment Availability

Although the demand for AOD treatment is high, the majority of people requiring AOD treatment do not seek help. Those who do seek help often receive insufficient and inadequate treatment. This inadequacy may apply to people without health insurance or without AOD treatment coverage, gay men and lesbians, IDUs, HIV-infected AOD abusers, and people from cultural and ethnic minorities.

Inadequate treatment slots in the public sector. The demand for public AOD treatment is extremely great, especially among the two largest groups treated by public AOD treatment programs—chronic AOD recidivists and the working poor. Chronic recidivists are people with severe addiction and prominent psychosocial dysfunction. They live from crisis to crisis, often with unmet basic needs. As chronic recidivists age, they exhaust AOD, mental health, and social service resources. Their crises become more severe and they require more from the AOD treatment program. Many are addicted to opioids and/or cocaine, and many engage in injecting drug use. As a group, they have a very high risk for HIV exposure as well as significant AOD treatment needs.

Chronic recidivists are people with severe addiction and prominent psychosocial dysfunction. They live from crisis to crisis, often with unmet basic needs. Many are addicted to opioids and/or cocaine, and many engage in injecting drug use.

As a result of tremendous demand for public AOD treatment, many programs have long waiting lists. Thus, some people who need and want treatment may select a treatment modality that is inappropriate but available. In an effort to address problems related to AOD treatment

availability, in 1993 the Federal Government published interim revised regulations that applied to States and AOD treatment programs receiving Federal substance abuse prevention and treatment block grant funds. The interim revised regulations, which are referred to throughout this TIP, are summarized in Appendix B.

Insufficient third-party coverage. Insurance companies and other third-party payers tightly control the type and intensity of AOD treatment coverage. Inpatient treatment is often limited to a few days of detoxification and management of psychiatric crises. Patients are rapidly moved to lower levels of intensity, based on coverage decisions by insurance and managed care company representatives.

Summary

AOD addiction is a chronic, progressive, biopsychosocial disease that is best treated by a biopsychosocial multidisciplinary treatment approach. Treatment can be provided by different types of providers (private sector and public sector); at different levels of care (inpatient, intensive outpatient, and outpatient); and through different program models (residential, day and evening treatment programs, and halfway homes). Treatment may include detoxification and maintenance on substitution therapy.

Substance abuse treatment has been shown to be an effective context in which to provide other treatment services to AOD abusers who might otherwise have no access to such services (O'Connor et al. 1992; Samet et al., 1992b; Umbricht-Schneiter et al., 1994). All types of AOD treatment involve contact with patients needing a variety of services related to HIV/AIDS, such as HIV testing, counseling, education, advocacy, case management, liaison with AIDS services and support groups, and medical care for HIV and related conditions.

Footnotes

1

. This chapter was written for the TIP by Mim Landry, Coralee Hoffman, and Carolyn Davis.

TIP 15: Chapter 3 - Primary Medical Care for HIV-Infected AOD Abuse Patients[1]

Providers of medical care to people who are HIV-infected and who abuse alcohol and other drugs (AODs) face several significant challenges: overcoming the systemic and emotional barriers that keep many of these patients out of the healthcare system, empowering patients who enter the system to be active participants in their own care, and keeping abreast of the latest recommendations concerning the care of HIV-infected individuals at a time when knowledge of the nature and course of HIV infection is evolving rapidly.

Both HIV and AOD abuse are chronic diseases, and there are many similarities between HIV care and AOD abuse treatment. Yet, an uneasy relationship frequently exists between the fields of medicine and AOD abuse treatment. Staff of AOD abuse treatment programs may see a focus on medical care for HIV infection as counterproductive to patients' recovery from AOD abuse. Medical providers may harbor judgmental attitudes about AOD abusers. In turn, AOD abusers may distrust their medical care providers (Gerbert et al., 1991).

Clinical experience demonstrates, however, that patients with both AOD addiction and HIV infection need integrated care to attain satisfactory outcomes. The need for integrated treatment of HIV infection and AOD abuse must be continually emphasized to both patients and healthcare providers. Providers in medical care and AOD abuse treatment settings have a responsibility to overcome their differences in the interests of their patients.

Barriers to Care for HIV-Infected AOD Abuse Patients

Bringing AOD abusers with HIV infection into the healthcare system is a significant challenge. Several studies have shown that most HIV-infected AOD abuse patients delay seeking medical care. In one study, 24 percent of HIV-positive patients waited more than a year after learning of their status to present for primary care. The median CD4+ cell count of these patients at presentation was in the 300s, below the threshold at which HIV-related medical therapy should be considered (Samet et al., 1992b).

Why patients wait so long to seek treatment is not well understood. Factors such as lack of financial resources, lack of health insurance, shortage of treatment slots, and the difficulty of navigating the treatment system probably play a part. In addition, individuals may be reluctant to enter a healthcare system they perceive as unsympathetic.

The structure of many healthcare systems and the behavior of many healthcare providers can reinforce AOD abusers' view of themselves as failures. Individuals' feelings of helplessness about addressing their AOD abuse may feed into a general sense of helplessness about taking care of their health problems. Denial may also cause individuals to minimize their medical problems in general, and HIV infection in particular. When HIV-infected AOD abusers do seek medical attention, they tend to make excessive use of acute and emergency care services and to underuse primary care medical services.

The need for integrated treatment of HIV infection and AOD abuse must be continually emphasized to both patients and healthcare providers.

Achieving Integration of Care

To achieve integration of care for HIV-infected AOD abuse patients, linkages must be developed and communication maintained between providers of AOD abuse treatment and HIV medical care. Existing links between primary medical care and substance abuse treatment (such as those that have been established in some managed care organizations) must be built upon to expand services and improve access to care (Selwyn et al., 1989, 1993; O'Connor et al., 1992).

To achieve integration of care for HIV-infected AOD abuse patients, linkages must be developed and communication maintained between providers of AOD abuse treatment and HIV medical care.

The 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule reinforces the importance of linkages between AOD treatment and primary care services, particularly in the provision of services to injecting drug users (IDUs). For example, the regulations require that

IDUs on a waiting list for AOD treatment receive interim services within 48 hours of requesting them. Interim services must include referrals to HIV healthcare services as well as HIV counseling and education. (See summary of interim block grant regulations in Appendix B. See also list of resources in Appendix G.)

All AOD abuse treatment programs should be capable of conducting HIV risk assessments and providing basic HIV education and counseling to patients. In addition, all programs should provide access to HIV testing and pre- and posttest counseling. If programs cannot provide testing and related counseling onsite, they must have formal relationships with other agencies that will provide these services for patients referred by the program.

All AOD abuse treatment programs should be capable of conducting HIV risk assessments and providing basic HIV education and counseling to patients. In addition, all programs should provide access to HIV testing and pre- and posttest counseling.

For guidance on structuring HIV counseling programs, providers should consult the U.S. Centers for Disease Control and Prevention (CDC) Technical Guidance on HIV Counseling (CDC, 1993f.)

Staff of primary care facilities serving HIV-infected AOD abuse patients should understand and be responsive to these patients' needs (Libman et al., 1992; Samet et al., in press). They should be aware that a patient's relapse into AOD abuse may result in noncompliance with medical care. In addition, staff must be sensitive to cultural variations and issues surrounding race and ethnicity, sexual orientation, life experiences, and gender. (See section on cultural competence of providers in Chapter 1.)

Providers of primary care for HIV-infected persons should ask questions about the status of their AOD abuse. Patients need continual reinforcement of the message that, by continuing to abuse AODs, they are further damaging their own health as well as placing others at risk of HIV infection. Many of the skills used in HIV treatment are also inherent in AOD abuse treatment. For example, treatment of both disorders should emphasize survival, assertiveness, and patients' empowerment to address their illnesses.

Models of Medical Care for An AOD Abuse Population

Medical Care Within AOD Abuse Treatment Programs

Exhibit 3-1 Models of Medical Care in AOD Treatment

(more...)

Chapter 2 of this Treatment Improvement Protocol (TIP) provides an overview of AOD abuse treatment settings and modalities. Exhibit 3-1 contains a description of the various models for the provision of medical care in AOD abuse treatment programs.

Models of Primary Care for an AOD Abuse Population

Few well-defined models exist for providing primary care to HIV-infected AOD abuse patients within AOD abuse treatment programs. Unfortunately, much of this population's medical care occurs in hospital emergency departments. Finding primary care physicians or clinics willing to accept HIV-infected AOD abuse patients can be a major problem.

There is a need to evaluate existing models of primary care to identify how they can be modified and expanded to address the special needs of the HIV-infected AOD abuse population (O'Connor et al., 1992; Selwyn et al., 1993). There have been no studies of outcomes for patients referred to available community primary care resources. One study that compared onsite with offsite primary care for a small group of subjects found that onsite care provided in an AOD treatment setting had significant advantages (Umbricht-Schneiter et al., 1994).

From 1989 to 1992, the Health Resources and Services Administration (HRSA) and the Center for Substance Abuse Treatment (CSAT) funded 15 demonstration projects linking primary care services and AOD abuse treatment. Information about the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (the CARE Act) is provided in Appendix E.

Onsite Systems

Exhibit 3-2 Components of Onsite Medical Systems

AOD abuse treatment programs that have developed onsite provision of primary care medical services have tended to be hospital- or university-affiliated programs able to benefit from a close association with affiliated medical specialists. Experience with such onsite systems demonstrates them to be beneficial where the resources exist to establish and maintain them. (See Exhibit 3-2 and accompanying box outlining the services at Substance Abuse Services, the clinic for HIV-infected AOD abuse patients at the San Francisco General Hospital.)

Referral Systems

Few AOD abuse treatment programs have sufficient resources to provide onsite HIV primary care services. It is recommended that programs without such resources establish referral systems to provide primary healthcare services through linkages with community healthcare centers, public health clinics, private providers, or hospitals. Boston City Hospital has operated an exemplary program with well-established linkages since 1990; see accompanying box.

The practice of distributing patients to various clinical sites for primary care has been referred to as a distributive care system (Samet et al., in press). Optimally, such a system should be multidisciplinary, with social workers, physicians, physicians-in-training, nurses, and counselors included among the treatment staff. A case manager may be helpful in facilitating a referral system.

Communication. When patients are sent to referral sites for primary medical care, a communication system should be in place to ensure that appointments are kept and that information about patients' medical care is sent back to the referral point. A memorandum of understanding (MOU) between the referral site and the primary care provider is recommended to ensure that this feedback occurs systematically.

The 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule requires States to coordinate AOD prevention and treatment activities with other services, including HIV services. MOUs may be cited as evidence that such coordination is being sought. (See summary of block grant interim regulations in Appendix B.)

Contractual Arrangements

Some HIV services may be provided by contractual arrangement with other healthcare facilities. For example, patients with identified health problems, such as positive tuberculin skin test results, may be sent to a local hospital or other facility with which the referring facility has a contractual arrangement. The contractual arrangement guarantees that the patient will be seen and specifies the services to be rendered. Unlike referrals, contractual arrangements contain a built-in mechanism that ensures continuity of care.

Exhibit 3-3 Recommended Elements of a Contractual Arrangement

(more...)

Recommended elements of a contractual arrangement for primary medical care services are described in Exhibit 3-3.

Medical Standards of Care

As noted in the introduction to this chapter, knowledge about the nature and course of HIV infection is evolving rapidly. There remain, however, many unanswered questions concerning what constitutes optimal treatment for HIV disease itself and some of its manifestations. As a result, a range of acceptable clinical practice exists.

The purpose of this section of the Treatment Improvement Protocol (TIP) is to describe that range of practice endorsed by the CSAT consensus panel members. This is not a treatment handbook, however. Where specific treatment recommendations exist, or where data strongly

indicate that a particular intervention is superior to alternative treatments, that information is clearly stated. Where there are arguments for and against a particular intervention, both the advantages and disadvantages are discussed.

The panel's intent is to provide clinicians treating HIV-infected AOD abuse patients with current information on which to base clinical decisions that are in the best interests of their patients. The reader is also referred to several excellent sources of information on current HIV/AIDS care, with special reference to primary care and outpatient management (Advisory Group on HIV Early Intervention, 1994; Agency for Health Care Policy and Research, 1994; Broder et al., 1994; Gallant et al., 1994; Jewett and Hecht, 1993; Hecht and Soloway, 1992-1993; Libman and Witzburg, eds., 1993).

Classification of HIV Infection and AIDS

Exhibit 3-4 1993 Revised Classification System for (more...)

Exhibit 3-4 1993 Revised Classification System for HIV Infection and Expanded AIDS Surveillance Case Definition for Adolescents and Adults

1993 Revised Classification System for HIV Infection and Expanded AIDS Surveillance Case Definition for Adolescents and Adults			
	Clinical Categories		
CD4+ T-cell categories	**(A) Asymptomatic, Acute (Primary)**	**(B) Symptomatic, Not**	**(C) AIDS-- Indicator**

	HIV or PGL*	**(A) or (C) Conditions**	**Conditions**
(1) >=500/µL	A1	B1	C1
(2) 200-499/µL	A2	B2	C2
(3) <200/µL AIDS-Indicator T-cell count	A3	B3	C3

(Shaded area indicates that the individual has AIDS.) **CD4+ T-Lymphocyte Categories** The three CD4+ T-lymphocyte categories are defined as follows:

- **Category 1:** >500 cells/µL
- **Category 2:** 200--499 cells/µL
- **Category 3:** <200 cells/µL

These categories correspond to CD4+ T-lymphocyte counts per microliter of blood and guide clinical and therapeutic actions in the management of HIV-infected adolescents and adults. The revised HIV classification system also allows for the use of the percentage of CD4+ T-cells. HIV-infected persons should be classified based on existing guidelines for the medical management of HIV-infected persons. Thus, the lowest accurate, but not necessarily the most recent, CD4+ T-lymphocyte count should be used for classification purposes.

Clinical Categories The clinical categories of HIV infection are defined as follows: ***Category A*** Category A consists of one or more of the conditions listed below in an adolescent or adult (>= 13 years) with documented HIV infection. Conditions listed in Categories B and C must not have occurred.

- Asymptomatic HIV infection
- Persistent generalized lymphadenopathy

- Acute (primary) HIV infection with accompanying illness or history of acute HIV infection

Category B Category B consists of symptomatic conditions in an HIV-infected adolescent or adult that are not included among conditions listed in clinical Category C and that meet at least one of the following criteria: a) the conditions are attributed to HIV infection or are indicative of a defect in cell-mediated immunity, or b) the conditions are considered by physicians to have a clinical course or to require management that is complicated by HIV infection. *Examples* of conditions in clinical Category B include, *but are not limited to*

- Bacillary angiomatosis
- Candidiasis, oropharyngeal (thrush)
- Candidiasis, vulvovaginal: persistent, frequent, or poorly responsive to therapy
- Cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*
- Constitutional symptoms, such as fever (38.5 C) or diarrhea lasting >1 month
- Hairy leukoplakia, oral
- Herpes zoster (shingles), involving at least two distinct episodes or more than one dermatome
- Idiopathic thrombocytopenic purpura
- Listeriosis
- Pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess
- Peripheral neuropathy.

For classification purposes, Category B conditions take precedence over those in Category A. For example, someone previously treated for oral or persistent vaginal candidiasis (and who has not developed a Category C

disease) but who is now asymptomatic should be classified in clinical Category B. ***Category C*** Category C includes the clinical conditions listed in the AIDS surveillance case definition (Appendix below). For classification purposes, once a Category C condition occurs, the person will remain in Category C.

APPENDIX. Conditions Included in the 1993 AIDS Surveillance Case Definition

- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical Cancer, invasive **
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcoses, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1 month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (>1 month's duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (>1 month's duration)
- Kaposi's sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary, of brain
- *Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary
- *Mycobacterium tuberculosis*, any site (pulmonary or extrapulmonary)
- *Mycobacterium*, other species or unidentified species,

disseminated or extrapulmonary

- *Pneumocystis carinii* pneumonia
- Pneumonia, recurrent**
- Progressive multifocal leukoencephalopathy
- Pulmonary pneumonia**
- *Salmonella* septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

* PGL-persistent generalized lymphadenopathy. Clinical Category A includes acute (primary) HIV infection. **Added as AIDS-defining illness in the 1993 expansion of the AIDS surveillance case definition, when occurring in persons with HIV infection.

Source: CDC, 1992a

In 1993, CDC established a new classification system for HIV infection and AIDS, replacing earlier systems. The new classification system includes a matrix of clinical and laboratory parameters that enable physicians to categorize patients according to disease severity. CDC also expanded its list of AIDS-defining conditions to include a CD4+ cell count of less than 200, cancer of the cervix, pulmonary tuberculosis, and recurrent bacterial pneumonia (CDC, 1992a) as AIDS-defining conditions in HIV-seropositive persons (see Exhibit 3-4).

These changes were intended in part to remedy the underestimation of AIDS incidence in IDUs, people of color, and women that occurred under previous classification systems. Preliminary analysis of the impact of these definitional changes on the reporting of AIDS cases indicates that these groups are better represented in the newly included clinical categories than formerly.

Clinicians should become familiar with the new HIV/AIDS classification system, not only because of its clinical implications, but also because patients' eligibility for social service entitlements may be linked for certain conditions to the revised HIV/AIDS case definition.

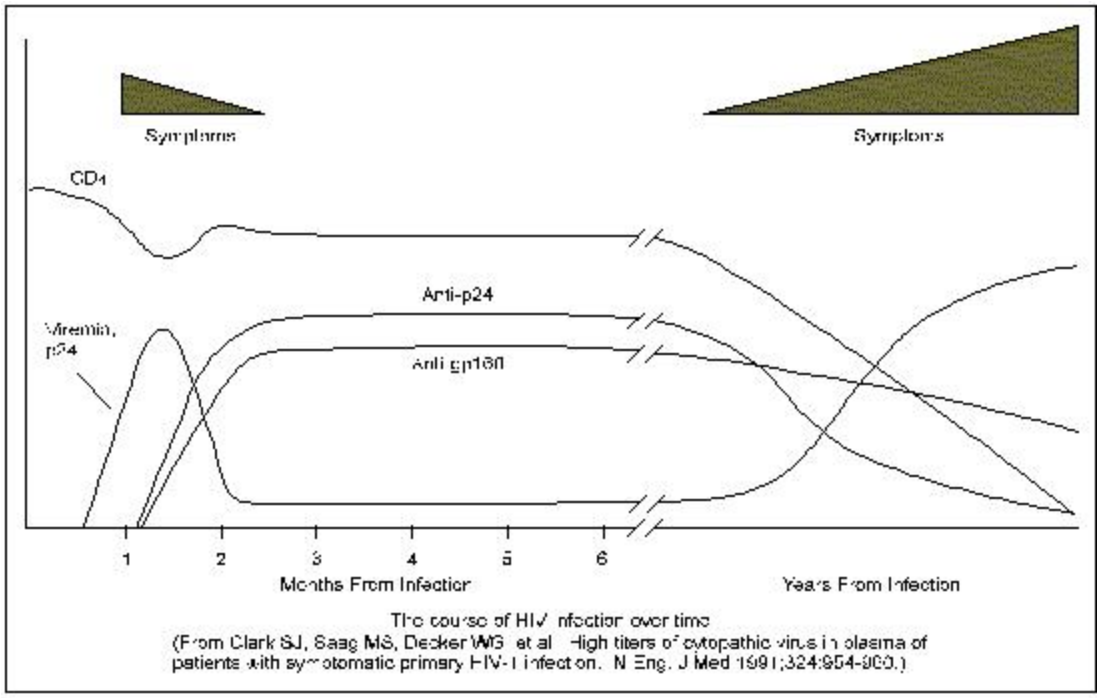
Natural History of HIV Infection

The natural history of HIV infection suggests that the great majority of infected persons will eventually develop AIDS. Although there are wide individual variations, current epidemiological data suggest that the average time from initial infection with HIV to the development of clinical AIDS—in the absence of preventive interventions -- is at least 10 years. It has also been clearly shown that both antiretroviral therapy (i.e., anti-HIV therapy) and prophylactic regimens against opportunistic infections such as *Pneumocystis carinii* pneumonia (PCP) can increase the length of the asymptomatic period and in some cases have a favorable impact on survival once patients become symptomatic (Graham et al., 1991, 1992; Lundgren et al., 1994; Moore et al., 1991; Osmond, 1994).

Although there has been much recent controversy concerning the appropriate timing of initiation of antiretroviral therapy, it is clear that a fundamental change has taken place over the last decade in the medical approach to HIV infection and disease. It is now appropriate to think of HIV infection and AIDS as *chronic conditions* requiring ongoing care and management. This approach contrasts sharply with the situation in the early years of the HIV epidemic, when AIDS frequently presented as a fulminant illness with high short-term mortality.

It is now appropriate to think of HIV infection and AIDS as chronic conditions requiring ongoing care and management.

Exhibit 3-5

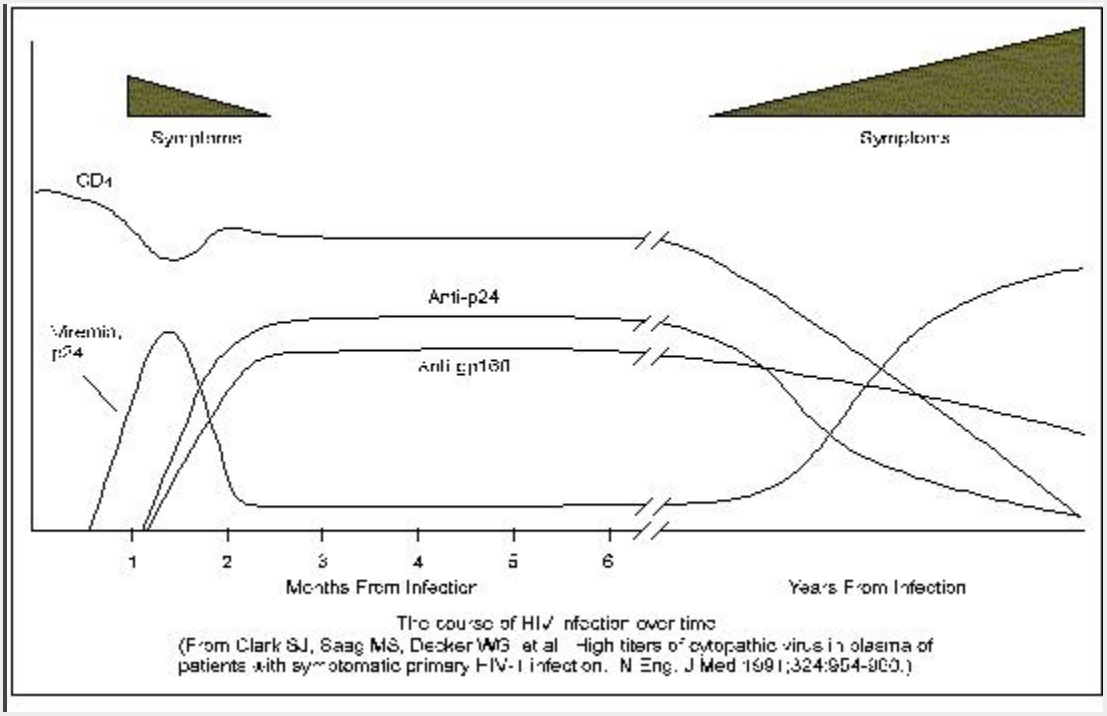


The course of HIV infection over time
(From Clark SJ, Saag MS, Decker WD, et al. High titers of cytopathic virus in plasma of patients with symptomatic primary HIV-1 infection. N Eng. J Med 1991;324:954-960.)

Exhibit 3-5

This change has important implications for AOD treatment programs, which can expect to see an increasing proportion of patients with HIV infection, both asymptomatic and symptomatic, in treatment over long periods of time. The rationale for incorporating comprehensive HIV care into

AOD treatment programs will only grow stronger in coming years. (See Exhibit 3-5



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Benefits of Identifying HIV-Infected Patients

As noted in Chapter 1 of this TIP, wide variations exist in the prevalence of HIV infection among AOD abusers with respect to geographic region, demographic factors, and sampling context. It is clear, however, that chemically dependent persons -- particularly IDUs -- are at high risk for acquiring HIV. In addition to the central role of shared needle use as a vector for HIV transmission, substance use increases the risk of infection with HIV by reducing individuals' inhibitions and increasing the likelihood that they will engage in high-risk sexual practices. Half of all AIDS cases diagnosed in women in the United States to date have been in female AOD users.

Many AOD abusers may be unaware that they are HIV-infected. Individuals at risk of HIV infection are often reluctant to be tested because of denial, fear of stigmatization, or a belief that "nothing can be done." However, early identification of HIV-infected persons is important both for public health reasons and because patients can benefit from early medical intervention:

- **Risk reduction education** can prevent transmission of HIV by encouraging infected individuals to adopt safer sex and drug-using practices.
- **TB screening and prophylaxis** can prevent progression to active TB and transmission of this highly infectious condition to others. IDUs are at risk of being coinfected with HIV and TB.
- **Vaccinations** recommended in HIV-infected persons (for pneumococcal pneumonia, influenza, and hepatitis B) are more effective when administered early in the course of HIV infection, before patients' immune systems are severely compromised.
- **Zidovudine therapy** and, increasingly, therapy with other antiretroviral medications may play a role in helping to prevent disease progression and improving immune function. Zidovudine is now recommended for HIV-infected pregnant women because it has been shown to reduce perinatal transmission of HIV from mother to infant.
- **Prophylaxis** against opportunistic infections, particularly PCP has clearly been shown to be an effective, safe, and simple strategy for reducing morbidity and mortality from certain common HIV-related diseases.

AOD abuse treatment programs should encourage their patients to be tested for HIV infection. If onsite testing is not feasible, programs should develop linkages with HIV testing facilities. However, patients have a right to refuse HIV testing and cannot legally be denied AOD treatment if they so refuse. (See Chapter 7.)

AOD abuse treatment programs should encourage their patients to be tested for HIV infection.

Significance of CD4+ Cell Counts

CD4+ T-lymphocytes (also referred to as CD4+ cells, T-cells, or T-4 helper cells) are the subset of white blood cells in the immune system specifically targeted by HIV. Although HIV also infects

other types of cells, it is the virus's effects on CD4+ cells that cause most of the immunosuppression characteristic of HIV disease.

CD4+ cell counts are generally relied upon as surrogate markers for the stage of a patient's HIV disease. A normal CD4+ count is in the range of 800 to 1,500. However, for several reasons, it is advisable that clinicians not attach excessive importance to CD4+ counts. Although they reflect the overall status of the immune system and are presumed to reflect the stage of illness, CD4+ counts can fluctuate over time. Results can also vary among different laboratories and be affected by factors such as intercurrent (coexisting or intermittent) illness and time of day. Measuring CD4+ counts during acute intercurrent illness is generally not recommended.

Exhibit 3-6 Recommended CD4+ Testing Frequencies and (more...)

Exhibit 3-6 Recommended CD4+ Testing Frequencies and Thresholds For Initiation of Antiretroviral Therapy

Recommended CD4+ Testing Frequencies and ThresholdsFor Initiation of Antiretroviral Therapy

Testing Frequency

- 500 and over = Every 6 months
- Less than 500 down to 50 = Every 3 months
- Less than 50 = Many experts see no need for testing (except in relation to initiation of new antiretroviral therapy, to observe whether therapy results in an increased CD4+ count).

Antiretroviral Therapy

Recommendations from the 1993 National Institute of Allergy and Infectious Diseases (NIAID) State-of-the-Art Conference (Sande et al., 1993):

Clinical Status	CDR+ Range, Cell Count	Recommendation
No Previous Antiretroviral Therapy		
Asymptomatic	>500	No therapy
Asymptomatic	200-500	Zidovudine or no therapy
Asymptomatic	<200	Zidovudine
Symptomatic	<200	Zidovudine
Previous Antiretroviral Therapy		
Stable	>300	Continue zidovudine
Stable	<300	Continue zidovudine or change to didanosine
Progressing	50 to 500	Change to didanosine or zalcitabine
Progressing	<50	Change to didanosine or zalcitabine
Intolerant to Zidovudine		
Stable or progressing	<50	Change to didanosine or zalcitabine

NOTE: Since the State-of-the-Art Conference made its recommendations, another antiretroviral agent--stavudine (d4T)-has been licensed by the Food and Drug Administration. The expert panel did not issue a formal recommendation on combination antiretroviral therapy (i.e., zidovudine + didanosine, zidovudine + zalcitabine, zidovudine + stavudine). However, combination therapy is an option that clinicians may wish to consider, and clinical trials are actively attempting to address the possible benefits and risks of this approach. Clinicians not familiar with this strategy should undertake consultation with an expert in HIV management before initiating combination therapy.

Also, CD4+ counts are only an indirect measure of viral activity. They measure the effects of the virus on the target cell, not the activity or virulence of the virus itself. Within the next 1 or 2

years, commercial blood tests that measure HIV viral activity more directly should become available. These new tests, which will be able to quantify viral levels in blood and determine strain type and other indicators of virulence, should have great clinical utility. For the time being, however, CD4+ lymphocyte counts are the best available measure of the extent of HIV-related immune suppression and disease progression. To obtain the most accurate information about trends in a patient's CD4+ levels over time, counts should be taken twice initially at intervals a few days apart and periodically thereafter. Long-term therapy can be based on the results of these tests. Exhibit 3-6 shows recommended CD4+ testing frequencies and thresholds for initiating antiretroviral therapy.

To obtain the most accurate information about trends in a patient's CD4+ levels over time, counts should be taken twice initially at intervals a few days apart and periodically thereafter.

The **CD4+ percent**, or the percentage of lymphocytes that are CD4+ helper cells, is an additional measurement often performed as part of basic CD4+ lymphocyte subset studies which include the CD4+ helper cell count. The CD4+ percent may display less variability than the CD4+ count.

In seeing HIV infection as a chronic rather than a terminal illness, clinicians need to be sensitive to the emotional overtones of CD4+ counts for HIV-infected patients. Patients may become overly invested in the meaning of a particular CD4+ count, distorting its importance within the context of their overall condition. Patients with low CD4+ counts can be relatively healthy and stable, while those with high counts can be clinically ill. It is recommended that information about a patient's CD4+ count be conveyed sensitively and within the context of the patient's overall clinical picture.

It is recommended that information about a patient's CD4+ count be conveyed sensitively and within the context of the patient's overall clinical picture.

Despite their limitations, CD4+ measurements are useful in indicating points at which treatment decisions must be made (for example, when counts are declining faster than expected or when

they reach certain set points). The average yearly decline of CD4+ cell counts in HIV-infected patients—particularly during the long period after primary infection and before the very late stages of illness, when absolute CD4+ declines may be greater and smaller, respectively -- is 60 to 85 cells per year.

However, the rate of decline is variable. Some patients' CD4+ counts decline rapidly while others remain stable for long periods. There is no evidence that CD4+ counts decline more rapidly in HIV-infected AOD abusers than in other HIV-infected populations (Graham et al., 1992; Margolick et al., 1992; Saag, 1994a).

Initial Assessment

Medical care provided to HIV-infected individuals will vary depending on the stage of the infection, but all patients should receive a minimum level of evaluation and followup (Jewett and Hecht, 1993). An assessment of behavior associated with transmission of HIV is an important part of the initial patient assessment. Medical providers need to be aware of the risks associated with activities, such as unsafe sex and drug practices, in which patients may engage.

At initial presentation and periodically thereafter, all AOD abuse patients should receive risk assessments and comprehensive medical examinations. These examinations may be performed onsite or at another facility through referral or a contractual arrangement. (See above, Models of Medical Care for an AOD Abuse Population, p. 20.)

As mentioned in the introduction to this chapter, staff of primary care facilities serving HIV-infected AOD abuse patients need to understand and be responsive to these patients' needs. They should be aware that a patient's relapse into AOD abuse may result in noncompliance with medical care. In addition, staff need to be sensitive to cultural variations and issues surrounding race and ethnicity, sexual orientation, life experiences, and gender. (See data regarding cultural sensitivity and competence, Chapter 1, Appendix D.)

Exhibit 3-7 Initial Comprehensive Medical Evaluation

(more...)

The following sections on medical history, physical examination, and laboratory tests are adapted from "HIV Infection: A Primary Care Approach" (Hecht and Soloway, 1992-1993) and the *Protocols for the Medical Care of HIV Infection* (New York State Department of Health, AIDS Institute, 1992). Providers of primary care to HIV-infected AOD abusers may find these materials useful. (See Exhibit 3-7.)

At initial presentation and periodically thereafter, all AOD abuse patients should receive risk assessments and comprehensive medical examinations.

Medical History

A thorough medical history is an important first step that enables the provider to proceed to clinical evaluation and formulation of a treatment plan. Taking the history may occupy an entire patient visit, particularly when it is combined with education and counseling. If the HIV test occurred elsewhere, it might be helpful to begin by inquiring when the patient took the test and why. This query may elicit some information about the patient's medical history and risk behaviors. Questions about drug use and sexual practices should be explicit and clear. Documentation of the HIV-positive test result, if performed elsewhere, should also be obtained and noted in the record.

Sometimes the risk history will provide an indication of the duration of the patient's infection. If so, the provider may wish to discuss the usual latency period of HIV and implications of the patient's history for determining the stage of the disease and the prognosis. Patients should be thoroughly counseled on **risk reduction** and encouraged to notify past and present sexual or drug use contacts of their HIV status. **Contact notification** is a difficult issue for many patients, but most people can be persuaded to cooperate once they understand that their contacts may be at serious risk.

The next step in the history taking may be to ask questions about specific **symptoms of HIV infection** (for example, fevers, night sweats, diarrhea, weight loss, lymphadenopathy, thrush, vaginitis, or skin changes) or symptoms suggesting undiagnosed **AIDS-defining conditions** (for example, mental status changes, visual changes, severe headaches, chronic diarrhea, shortness of breath, or difficulty swallowing).

Questioning about past medical history should particularly cover previous diagnoses and/or treatment of tuberculosis, syphilis, genital herpes, and (in women) abnormal Pap smears. It is important to address **sexual behavior** in HIV-infected AOD abusers because of the prevalence of sexual disinhibition related to AOD use. Sexually transmitted diseases (STDs) are common in AOD abusers, particularly among women involved in commercial sex work or the exchange of sex for drugs.

The patient's **immunization history** should be recorded.

Specific information should be collected about the patient's **social situation**, including functional status, housing, employment, health insurance, and social support from family members or significant others. These questions may identify urgent social needs and prompt immediate referral to a social service agency or provider.

At the conclusion of the visit, a tuberculin skin test should be done, a set of laboratory tests performed or ordered, and one or more needed immunizations given. (See Exhibit 3-7 and text.) At the next visit, a full physical examination can be done and lab results reviewed.

Physical Examination

A careful physical examination is an essential part of the initial evaluation of HIV-infected patients. The physical exam can result in the diagnosis at an asymptomatic stage of a variety of complications that present a significant risk in this patient population. The exam also provides baseline data on which future clinical decisions may be based.

Fevers are common in HIV-infected patients and may be an indication of opportunistic infection. Weight loss greater than 10 percent of body weight, combined with chronic fever or diarrhea, establishes the AIDS-defining "wasting syndrome."

Cytomegalovirus retinitis is a common complication associated with changes in or loss of vision that is almost always seen in patients whose CD4+ counts are below 100.

Thrush and other oral lesions are also exceedingly common. Thrush should be treated with antifungal agents, for example, nystatin, clotrimazole, or fluconazole; it is also an indication for starting PCP prophylaxis, even if the CD4+ count is above 200.

Regular examination of **lymph nodes** should be considered. Lymphadenopathy in persons with HIV infection is not always caused by HIV alone. Fine-needle aspiration of lymph nodes in patients with marked or rapidly increasing adenopathy may lead to a treatable diagnosis.

Skin abnormalities are common. A regular examination of the entire skin surface may reveal treatable conditions ranging from seborrheic dermatitis to Kaposi's sarcoma.

Because women with HIV infection may have a high prevalence of **cervical abnormalities,** regular Pap smears—every 6 months or at least annually -- are advised. In sexually active women, the **pelvic exam** should include testing for gonorrhea and chlamydia because these infections may increase the risk of pelvic inflammatory disease.

Laboratory Tests

Limited information is available on which to base recommendations for the routine use of most laboratory studies in HIV-infected patients. These suggestions should be adapted to the particular circumstances of the individual patient and physician.

CD4+ counts. As noted above, CD4+ counts at present remain the standard laboratory test to assess the level of immune dysfunction in HIV-infected patients. As mentioned, it is preferable if

possible to perform two CD4+ tests a few days apart to help determine a baseline and assess patients' eligibility for antiretroviral therapy more accurately.

Blood counts. A complete blood count (CBC) can alert the clinician to blood abnormalities common in HIV-infected patients, including anemia, leukopenia, and thrombocytopenia. In patients receiving zidovudine, the frequency of CBCs is determined by the need to monitor for hematologic toxicity. In symptomatic patients not on zidovudine, CBCs can be repeated at 3- to 6-month intervals; in asymptomatic patients not on zidovudine, repetition every 6 to 12 months is advised.

Screening chemistries. Routine screening chemistries are recommended annually. Testing at 2- to 4-month intervals is indicated in patients receiving medications with potential liver, kidney, and muscle toxicity.

Syphilis. Annual serologic screening for syphilis is recommended.

Toxoplasmosis. Baseline testing is useful to identify patients with past exposure to toxoplasma, who may benefit from prophylaxis against this infection. Without prophylaxis, such patients have about a 30 percent chance of developing cerebral toxoplasmosis in the course of their HIV infection (especially when CD4+ counts drop below 100). Annual testing is advised in patients without prior exposure.

Hepatitis B virus (HBV). The prevalence of past exposure to HBV approaches 90 percent in many HIV-infected AOD populations in the United States. Because of the cost of the HBV vaccine, it may be cost effective to screen patients for exposure to this virus to determine if vaccination is necessary; vaccination is indicated for HIV-infected patients without previous exposure (i.e., all markers negative).

Hepatitis A and C. Injection drug users (IDUs) are also at risk for hepatitis A infection (although the reason for this has not been determined) and hepatitis C infection, which is parenterally transmitted like hepatitis B. While no effective treatment exists for either one of these conditions (hepatitis A is usually benign and self-limited, and hepatitis C may be treated

with injected interferon-alpha, but this treatment is expensive and impractical and often causes unpleasant side effects), it may be helpful to determine the presence of prior viral hepatitis in patients likely to be exposed to increasing numbers of hepatotoxic medications used to treat HIV disease. This determination may be particularly important for hepatitis C, which appears to persist as a chronic, active infection much more commonly than is the case for hepatitis B.

Chest x-ray. A chest x-ray is optional in the initial patient evaluation. Routine chest x-rays have been advocated to provide a "baseline" when patients present with respiratory symptoms, but there are no studies to support this recommendation. CDC suggests performing routine chest x-rays in anergic patients to look for signs of latent TB. Chest x-rays may also be useful in patients with a past history of pulmonary disease or heavy smoking.

Evaluating Symptomatic Illness

Exhibit 3-8 Medical Complications of Substance Abuse (more...)

Exhibit 3-8 Medical Complications of Substance Abuse That May Affect Differential Diagnosis of IDUs With HIV Infection

Medical Complications of Substance Abuse That May Affect Differential Diagnosis of IDUs With HIV Infection		
	Possible Diagnoses	
Symptoms	**HIV-Related**	**Substance Abuse-Related**
1. Constitutional	HIV Infection *Mycobacterium*	Cocaine use Injection-related bacterial infections

• Anorexia • Weight loss • Fever • Night Sweats • Diarrhea	avium complex Tuberculosis	Tuberculosis Herion withdrawal
2. Pulmonary • Chest Pain • Cough • Shortness of breath	Bacterial pneumonia *Pneumocystis carinii* pneumonia (PCP) Tuberculosis	Cocaine use Tobacco use Aspiration pneumonia
3. Neurologic • Altered mental status • Psychosis • Seizures • Focal deficits • Peripheral neuropathy	HIV infection Toxoplasmosis Cryptococcoses Progressive multifocal leukoencephalopathy HTLV-1	Intoxication and withdrawl from • Herion • Cocaine • Alcohol • Benzodiazepines Drug-related chronic encephalopathy Pyogenic centeral nervous system infection Trauma Alcoholic polyneuropathy
4. Dermatologic • Pruritus • Rash	HIV dermatitis HIV-related thrombocytopenia	Drug-related pruritus Chronic hepatitis Cellulitis Alcohol/herion - induced thrombocytopenia Lymphedema
5. Miscellaneous	HIV-related	Localized infection Herion

• Lymphadenopathy • Uremia	lymphadenopathy HIV-related nephropathy	nephropathy

Source: Reprinted with permission from the New England Journal of Medicine (O'Connor et al., 1994)

Clinicians providing care to HIV-infected AOD abusers must be familiar with the clinical manifestations of HIV disease and aware that these manifestations can be difficult to distinguish from common medical complications of substance abuse. Differential diagnoses in HIV-infected AOD abusers can be challenging because both HIV infection and substance abuse have clinical effects on a wide range of organ systems. To provide optimal care to this population, clinicians must be fully aware of the medical effects of both substance abuse and HIV infection (O'Connor et al., 1994). Exhibit 3-8 lists common symptoms that may be related to either HIV infection or AOD abuse.

Anorexia, weight loss, and **fatigue** may be a complication of chronic cocaine use, may be caused by HIV infection, or may be symptoms of specific AIDS-related opportunistic infections (for example, *Mycobacterium avium* complex, cytomegalovirus, tuberculosis). **Tachycardia, flu-like illness, fatigue, abdominal pain**, and **diarrhea** may be symptoms of drug withdrawal, particularly opioid withdrawal, or they may be symptoms of acute or chronic HIV-related conditions.

Chest pain, coughing, and **shortness of breath** may be symptoms of "crack" cocaine use or of HIV-related pulmonary infections such as PCP. **Bacterial endocarditis** with fever, night sweats, and chest pain or other pulmonary effects may result from unsterile intravenous injection or may indicate HIV-related opportunistic infection. Heavy cigarette smoking in IDUs may also make it difficult to interpret symptoms such as shortness of breath or the results of pulmonary function tests.

HIV and its related opportunistic infections commonly affect the **nervous system**, resulting in conditions such as HIV-related dementia, central nervous system cryptococcoses and

toxoplasmosis, and HIV-related peripheral neuropathy. Drug intoxication or withdrawal can also have direct effects on consciousness, cognition, and behavior. Heroin and cocaine use may be responsible for stroke syndromes and other **cerebrovascular disease**. Alcoholic, nutritional, and traumatic **peripheral neuropathy syndromes** may also be more common in substance abusers than in the population as a whole.

HIV-Related Primary Care

As previously noted, HIV disease now fits the pattern of a chronic disease (with exacerbations and remissions) rather than a fulminant illness presenting suddenly and progressing rapidly to death. Patients require periodic use of acute care services and inpatient resources, especially in the latter stages of the disease. Over the last decade, however, as patients have experienced longer asymptomatic periods between illnesses, there has been an increasing emphasis on outpatient management and primary care for HIV infection.

Exhibit 3-9 Preventive Healthcare for Injection-Drug (more...)

Exhibit 3-9 Preventive Healthcare for Injection-Drug Users With HIV Infection

Preventive Healthcare for Injection-Drug Users With HIV Infection	
Complication	**Activity**
1. HIV infection:	Complete blood cell and CD4+ count Antiretroviral therapy (if indicated) Assessment for opportunistic infections Prophylaxis against opportunistic infections (e.g., *Pneumocystis carinii* pneumonia)

2. Bacterial infection:	Pneumococcal vaccination (recommended) *Hemophilus influenza* vaccination (to be considered)
3. Tuberculosis:	Skin testing (including assessment for anergy) Chest roentgenogram (x-ray) Isoniazid (INH) chemoprophylaxis, if indicated
4. Sexually transmitted disease:	Syphilis serology
5. Hepatitis:	Liver function testing Hepatitis serology (A, B, C) Hepatitis B vaccination
6. Cervical cancer:	Pap smear

Care strategies have incorporated both antiretroviral therapy and a wide range of prophylactic regimens to effectively prevent opportunistic infections. A recent study found, however, that preventive interventions such as TB prophylaxis and pneumococcal vaccine were used by only about 30 percent of eligible patients; use of preventive interventions was lowest among HIV-infected IDUs (Glassroth et al., 1994). (See Exhibit 3-9.)

Antiretroviral Therapy

Zidovudine (AZT) remains the first-line drug of choice in treating HIV infection; it is also the agent with which clinicians and researchers have the most experience. Zidovudine (one of a class of medications known as *reverse transcriptase inhibitors*) first entered clinical practice in 1987, when it was shown to decrease disease events and prolong survival in patients with symptomatic HIV infection and AIDS (Fischl et al., 1987).

In 1989, based on a multicenter trial in the United States conducted through the NIH-funded AIDS Clinical Trials Group, it was recommended that all patients with CD4+ counts of less than 500 should receive zidovudine, whether they were symptomatic or not. This recommendation was based on the observation that patients who received zidovudine progressed to AIDS more slowly than patients on placebo.

However, the drug had no impact on mortality. The overall burden of morbidity and mortality was low in the asymptomatic group, even among placebo recipients, compared with previous observations in patients with late-stage disease (Volberding et al., 1990; Fischl et al., 1990).

Conflicting study results. Subsequent studies also demonstrated zidovudine's efficacy in delaying HIV disease progression in mildly symptomatic patients. Several other studies, however, including the United States Veterans Administration trial and the more recent European "Concorde" trial, showed no clearcut benefit to zidovudine therapy in asymptomatic patients. Specifically, in the Concorde trial, immediate versus delayed therapy with zidovudine in asymptomatic patients conveyed no clearcut long-term survival benefit (Hartigan, et al., 1992; Aboulker and Swart, 1993).

However, a recent collaborative European-Australian trial did find benefit from the use of zidovudine in patients with CD4+ counts above 400. In this study, patients receiving zidovudine had a decreased rate of disease progression compared with a placebo group (Cooper et al., 1993). Further, there have been consistent clinical observations that zidovudine may be of greatest benefit in the first 1 to 2 years after initiation of therapy. Patients frequently show evidence that the medication's effectiveness declines over time (for example, CD4+ counts increase but later decline; new opportunistic infections occur, etc.) (Lundgren, et al., 1994; Osmond, et al., 1994).

Given these varying observations, it is understandable that there has been confusion concerning the appropriate use of zidovudine. However, recent studies suggest that withholding therapy in the asymptomatic phase may have potentially adverse consequences, just as there may be adverse consequences to initiating therapy before patients become clinically symptomatic. It has been observed, for example, that active HIV replication occurs within lymph nodes during the

clinically latent phase of disease. Although the patient is asymptomatic, the total viral burden of HIV is growing steadily, with increasing destruction of lymph node elements in the immune system (Fauci, 1993; Pantaleo et al., 1993).

Benefits of therapy. Despite the conflicting conclusions reached in different trials, evidence is generally consistent that once zidovudine therapy is initiated, patients experience a longer asymptomatic period and reduced frequency of disease events during the first year or several years they use the medication (Osmond et al., 1994; Lundgren, et al., 1994). It is also clear that use of zidovudine in the later stages of HIV disease confers a survival benefit.

The initiation of antiretroviral therapy should be presented to the patient as a choice and its potential advantages and disadvantages discussed fully. Many patients and clinicians would still opt for the use of a medication that is likely to result in several years' reduced morbidity in the hope that additional therapies become available to supplement or ultimately replace zidovudine. Clinicians and patients making decisions about initiating antiretroviral therapy with zidovudine may wish to consider that development and approval of additional types of antiretroviral agents are expected within 2 to 4 years (Saag, 1994b).

The initiation of antiretroviral therapy should be presented to the patient as a choice and its potential advantages and disadvantages discussed fully.

Other antiretroviral agents. Three other medications from the reverse transcriptase inhibitor class are now available for clinical use: didanosine (ddI), zalcitabine (ddC), and stavudine (d4T). Zidovudine has been shown to be the most effective agent for initial antiretroviral therapy, but several recent studies have examined the use of didanosine and/or zalcitabine, either alone or in combination with zidovudine after an initial period of zidovudine use (Abrams, 1994; Collier et al., 1993; Spruance et al., 1994).

It has become increasingly common for clinicians to use one of these agents either in combination with or as an alternative to zidovudine when patients develop zidovudine intolerance

or when their HIV disease continues to progress while they are taking zidovudine. Clinical practice in this area is continually evolving.

Preliminary data support the rationale for combination therapy. This approach is consistent with therapeutic approaches to tuberculosis and other chronic infections for which the emergence of drug resistance is decreased by the use of multiple agents.

Unfortunately, the currently available antiretroviral agents are all reverse transcriptase inhibitors, i.e., they all act at the same stage of the viral life cycle of HIV. The development of protease inhibitors, which attack viral replication at a later stage in the cycle, is soon expected to provide an additional class of agents that may work effectively in combination with the reverse transcriptase inhibitors.

Recommendations. A National Institute of Allergy and Infectious Diseases (NIAID) consensus panel recommended in late 1993 that zidovudine therapy be considered for asymptomatic patients with CD4+ counts between 200 and 500 and recommended to symptomatic patients and those with CD4+ counts of less than 200 (Sande et al., 1993). (See accompanying Quick Reference Summary.)

The current dosage of zidovudine generally recommended in the literature is 100 mg five times daily as a chronic regimen. However, alternative regimens, such as two capsules (100 mg) three times daily (i.e., 600 mg/day), are frequently prescribed and may be preferable if patients find it easier to comply.

Recent data indicate that zidovudine therapy may play a key role in preventing the perinatal transmission of HIV from mothers to infants (CDC, 1994a).

The NIAID panel also recommends substituting didanosine or zalcitabine for zidovudine in patients whose disease is progressing or who are intolerant to zidovudine. In a recent study, didanosine and zalcitabine demonstrated comparable efficacy when used as single agents in patients who were either not responding to or could not tolerate zidovudine (Abrams, 1994). In

practice, as noted above, clinicians frequently prescribe one of these agents in addition to zidovudine.

No formal NIAID recommendation exists concerning the use of stavudine, which was licensed by the Food and Drug Administration (FDA) in August 1994. In practice, however, stavudine is used to treat advanced HIV disease in patients who are intolerant to or worsening on other antiretroviral medications. It is not yet routinely used in combination therapy.

Side effects. Side effects of zidovudine include headaches, nausea, myalgias, and insomnia. Because side effects may affect adherence to the prescribed regimen, clinicians should discuss them with patients before initiating therapy. For many AOD abusers, the side effects of zidovudine mimic those of withdrawal from substances of abuse, especially opioids. Lowering the dosage may decrease side effects and achieve better patient adherence. The lowest effective daily dose is probably close to 300 mg/day; at this dosage level, full adherence to therapy becomes critical. More serious complications of zidovudine therapy include anemia, granulocytopenia, myopathy, and (rarely) hepatitis. Most of these complications are dose related.

Significant side effects of **didanosine** are gastrointestinal distress (for example, abdominal pain and diarrhea) and numbness and tingling in the extremities. Didanosine may cause pancreatitis, at times severe, and, less frequently, peripheral neuropathy.

Side effects of **zalcitabine** are numbness and tingling in the extremities, painful swallowing, and abdominal pain. Zalcitabine is less likely than didanosine to cause pancreatitis, but more likely to cause peripheral neuropathy and oral or esophageal ulcerations.

Because current data do not suggest a clear-cut therapeutic benefit for either of these agents, it is appropriate for the clinician to base his or her choice at least in part on the medication's side effects profile.

For example, when considering the addition or substitution of another antiretroviral agent for zidovudine, **zalcitabine** should be offered to patients who may be at greater risk for pancreatitis

or gastrointestinal symptoms. **Didanosine** should be offered to patients who may be at greater risk for peripheral neuropathy and/or oral ulcers.

In patients with preexisting pancreatitis or peripheral neuropathy, both didanosine and zalcitabine should be used with extreme caution.

Stavudine can cause numbness and tingling in the extremities, as well as peripheral neuropathy, liver function abnormalities, and pancreatitis. Because this drug was licensed relatively recently, clinical experience with it is more limited than with the other reverse transcriptase inhibitors. It is used in advanced HIV disease that is not responding to other antiretroviral therapy. Stavudine is not yet routinely used in combination therapy.

A new medication in the reverse transcriptase inhibitor class, **3TC,** is currently in clinical trials and is available through compassionate release protocol. Preliminary data suggest that it may be effective when used in combination with zidovudine.

Tuberculosis (TB)

(TB screening is required by law in many AOD programs. For legal requirements regarding TB screening and treatment, see Chapter 7.)

Injecting drug users are at particularly high risk of TB. This observation preceded the AIDS epidemic but has been noted even more dramatically in recent years as a result of HIV infection. IDUs are the population group at highest risk of coinfection with *Mycobacterium tuberculosis* and HIV; TB incidence has increased alarmingly in this population and its contacts.

AOD abuse treatment programs are ideal sites for implementing effective screening, case finding, and supervised therapy and prophylaxis regimens for patients identified as having TB infection. Ideally, because of the growing importance of TB in the HIV epidemic, all AOD treatment programs should provide TB screening and prophylaxis onsite. If an AOD program does not offer onsite TB treatment, patients should be referred to a local health department.

TB may be transmitted to patients and staff at AOD treatment programs. In certain areas, there is a risk of transmission of **multidrug-resistant (MDR) TB.** Effective TB screening, surveillance, and followup programs are therefore critical.

NOTE: Under the 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule, programs receiving block grant funds must *either* provide TB services onsite or make arrangements for patients to obtain them at another facility. (See summary of block grant interim regulations in Appendix B.)

Because of the growing importance of TB in the HIV epidemic, all AOD treatment programs should provide TB screening and prophylaxis onsite.

TB screening. The standard technique for determining the presence of TB infection (which usually exists in latent form) is the tuberculin skin test. Typically, this test involves the intradermal injection of 0.1 ml of 5-TU purified protein derivative (PPD) of tuberculin, which is placed on the forearm and examined for induration (firmness or hardness of the skin at the injection site) 48 to 72 hours later. HIV-infected patients in AOD abuse treatment programs should be screened by PPD skin testing at least annually and possibly every 6 months, depending on the prevalence of TB or the risk of it among the population in the surrounding community. See Quick Reference Summary on TB screening, prophylaxis, and treatment.

It is likely that patients with HIV infection will not react in the normal manner to the tuberculin skin test because of diminished skin test reactivity resulting from immunosuppression. For this reason, the standard for a positive test of $10 mm of induration has been changed to $5 mm of induration for patients with known or suspected HIV infection.

There are several recent publications that clearly describe current guidelines for TB screening, including:

- Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children. (Bass et al., 1994.)

- Tuberculosis and Human Immunodeficiency Virus Infection: Recommendations of the Advisory Committee for the Elimination of Tuberculosis (ACET). (CDC, 1989.)
- Screening for Tuberculosis and Tuberculosis Infection in High Risk Populations and the Use of Preventive Therapy for Tuberculosis Infection in the U.S. Recommendations of the Advisory Committee for the Eliminations of Tuberculosis. (CDC, 1990.)

Some patients who are coinfected with HIV and TB will not respond at all to PPD skin testing; this *false negative* reaction is caused by a weakened immune system. For this reason, companion skin testing for cutaneous anergy is recommended for all patients with known or suspected HIV infection. Patients with cutaneous anergy are unable to react to any skin test antigens. (See Anergy Testing, below.)

HIV-infected patients in AOD abuse treatment programs should be screened for TB by PPD skin testing at least annually and possibly every 6 months.

TB prophylaxis. The standard anti-TB prophylaxis in patients with positive tuberculin tests is isoniazid (INH) 300 mg orally once daily, accompanied by 25 to 50 mg of vitamin B6. Other possible regimens include a twice-weekly regimen of INH (15 mg per kilogram of body weight, to a maximum of 900 mg), plus 25 to 50 mg of B6.

Ideally, these regimens should be administered in a supervised manner, i.e., the patient should be observed ingesting the medication. AOD treatment programs are ideally suited to providing such supervised therapy and have become increasingly important for both TB prophylaxis and therapy of active TB.

Recent increases in the incidence of MDR-TB have further highlighted the important role of directly observed therapy (CDC, 1992b). MDR-TB results in part from inadequate or partial completion of therapy and subsequent emergence of TB bacteria that are resistant to

pharmacologic therapy. Directly observed therapy significantly reduces the risk of developing MDR-TB by ensuring that patients complete the course of treatment.

Companion skin testing for cutaneous anergy is recommended for all patients with known or suspected HIV infection.

The lifetime risk that a PPD-positive, non-HIV-infected individual will develop active TB is approximately 10 percent. However, the 1-year risk of active TB in PPD-positive HIV-infected patients is 7 to 10 percent (Moreno et al., 1993; Selwyn et al., 1989). Given this significantly increased risk of active TB in HIV-infected individuals, a more aggressive treatment approach is justified in these patients.

For this reason, the standard practice of not prescribing INH to persons over age 35 (because of the danger of liver toxicity) is inappropriate for HIV-infected patients. INH prophylaxis should be offered to these patients with very few exceptions. Individuals receiving INH who have chronic alcoholic liver disease or active viral hepatitis should be closely monitored for liver toxicity.

The minimal necessary duration of INH prophylaxis in HIV-infected patients has not been established. INH prophylaxis should be offered to HIV-infected patients for at least 12 months; there is some indication that a period of less than 9 months may not be adequate. Whether it is necessary to continue beyond 12 months has not been determined; preliminary data suggest that 12 months may be sufficient.

In TB-endemic areas, some clinicians may opt to offer continued INH prophylaxis to patients as long as they are tolerating the regimen, even if they exceed the initial 12-month course. The management of HIV/TB coinfected patients should be undertaken with current information from infectious disease and public health experts. Patients known to be HIV-negative who have positive tuberculin skin tests should receive 6 months of INH prophylaxis.

Anergy testing. As discussed above, companion skin testing for cutaneous anergy is recommended for all patients with known or suspected HIV infection because patients with weakened immune systems may have false negative reactions to tuberculin testing. Anergy is

most common at CD4+ counts below 200 but may be found even in patients with CD4+ counts above 500.

Anergy testing is usually most efficiently done at the same time as tuberculin testing. The preferred method of anergy testing uses several single intradermal antigens, for example, at least two of mumps, tetanus, and candida. The multiple-puncture tine test device (Multi-test-CMI, Merieux, Lyon) may be used, but separate single-antigen tests are preferable.

The antigen tests are read 48 to 72 hours after placement, at the same time the tuberculin skin test is read. Any induration at the site of the antigen test is considered indicative of the presence of a delayed type of hypersensitivity (DTH) skin test reactivity (i.e., that the patient's immune system is capable of responding to skin test antigens).

A negative reaction to all skin test antigens is considered indicative of cutaneous anergy. A negative PPD test in the presence of one or more reactive antigen tests is considered a *true negative* PPD. If all tests are negative, the patient is anergic; the PPD may be a false negative, and the patient should be evaluated for active TB. (See below.)

Management of anergic patients. Patients with cutaneous anergy should be evaluated for the presence of active TB with a chest x-ray and symptom screen (for example, persistent cough, fever, weight loss, night sweats). If any symptoms suggestive of TB are present, further diagnostic evaluation should be aggressively pursued.

Anergy not only indicates the possibility of a false-negative PPD, but also identifies patients at high risk for active TB. Several recent studies have documented that the risk of active TB may be as high as 5 to 10 percent per year among IDUs with cutaneous anergy and HIV infection -- similar to the risk in patients with HIV/TB coinfection (Selwyn et al., 1992b; Moreno et al., 1993). This risk may vary greatly by geographic region, depending on the background prevalence rate of TB in the population to which the AOD users belong (CDC, 1991b).

Anergy not only indicates the possibility of a false-negative PPD, but also identifies patients at high risk for active TB.

CDC recommends that 12 months of INH prophylaxis be considered for anergic HIV-infected patients in populations in which the estimated prevalence of M. tuberculosis infection is greater than 10 percent (CDC, 1991b). Most populations of IDUs in the northeastern United States, as well as in certain other regions, are in this category.

Medical care and drug treatment providers should consult actively with public health authorities to determine the estimated prevalence of *M. tuberculosis* infection in their population before considering whether INH prophylaxis is appropriate for all anergic HIV-infected patients. The effectiveness and minimal necessary duration of prophylaxis in anergic HIV-infected patients has not been determined.

Management of patients with active TB. Active TB may progress more rapidly in HIV-infected patients. Patients who are coughing should be evaluated as soon as possible for active TB. Facial tissues should be readily available at treatment programs and patients should be instructed to use them to cover their mouths and noses if they cough or sneeze. Medical staff of AOD abuse treatment programs should consider asking patients who are coughing persistently to wear masks until they have been fully evaluated for TB.

Patients with active TB should be hospitalized and isolated for approximately 2 weeks of pharmacotherapy. They may be seen in AOD treatment programs after 2 weeks of treatment, once they are determined to be no longer contagious, but they must continue daily, observed TB treatment. Patients with TB and those at high risk for contracting it should be housed in a facility with adequate ventilation and respiratory isolation capability.

For guidance on the control of TB, programs should consult CDC's TB control recommendations, published in the *Federal Register* (CDC, 1994b).

Patients with active TB need to be hospitalized and isolated for approximately 2 weeks of pharmacotherapy.

Prophylaxis Against Opportunistic Infections

Exhibit 3-10

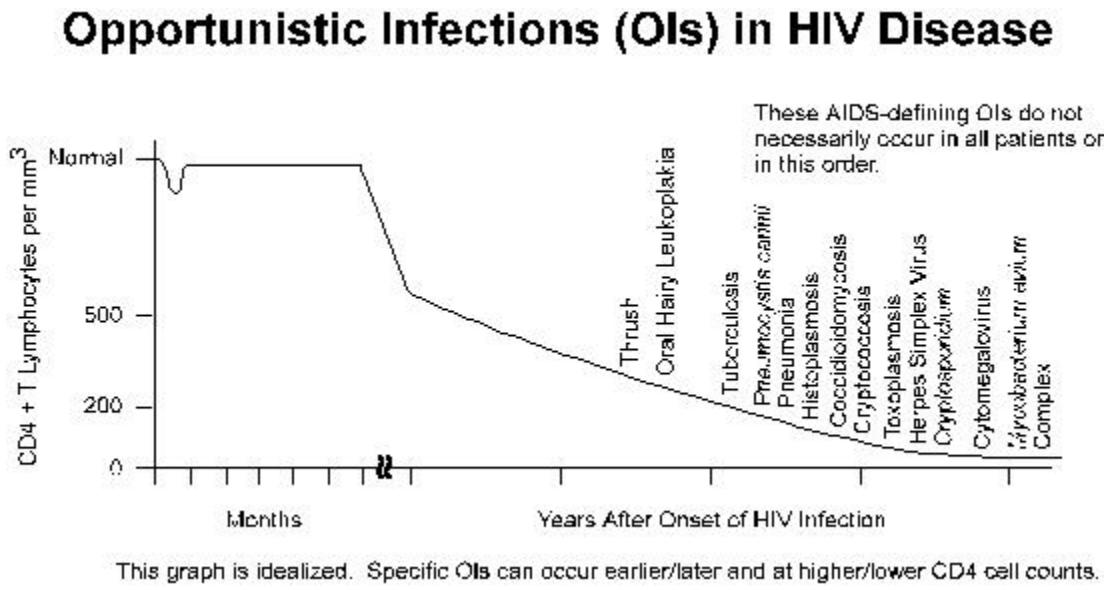
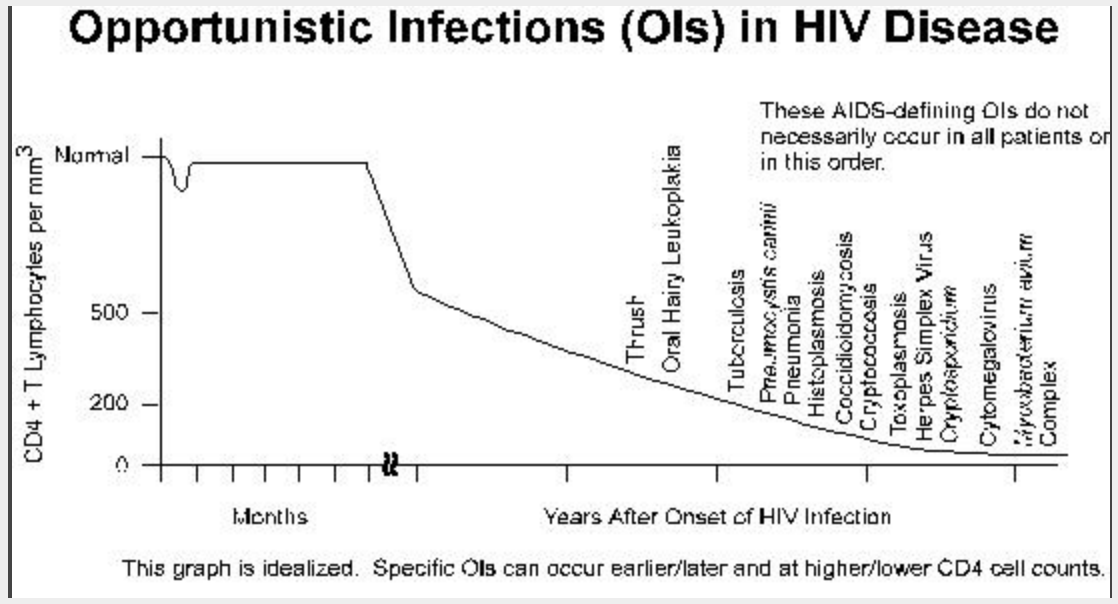


Exhibit 3-10

Current strategies for HIV care include the more widespread use of prophylactic regimens to help prevent specific opportunistic infections. As patients survive for longer periods with lower CD4+ counts, it will become increasingly important to develop additional prophylactic regimens for infections that occur at more advanced stages of immunosuppression. An excellent recent review summarized current practice regarding prophylaxis of opportunistic infections in HIV-infected patients (Gallant et al., 1994). (See (Exhibit 3-10



and the following Quick Reference Summary box on prophylactic regimens).

Pneumocystis carinii pneumonia (PCP) prophylaxis. The first and most important opportunistic infection for which prophylactic regimens were developed was PCP, which was previously the most common opportunistic infection in patients with AIDS. The widespread use since the late 1980s of prophylaxis against PCP has resulted in a dramatic decrease in the incidence of this opportunistic infection during the last 5 years (Hoover et al., 1993).

The risk of PCP increases significantly when a patient's CD4+ count declines to about 200. It is recommended that all patients with CD4+ counts of 200 or below receive ongoing PCP prophylaxis. HIV-infected patients who have histories of oral candidiasis, recurrent bacterial infections, tuberculosis, and chronic constitutional symptoms should also be offered PCP prophylaxis regardless of their CD4+ cell levels because of their high risk of progression to AIDS.

In addition, anyone who has already had PCP, regardless of CD4+ cell count, should receive prophylaxis because of the high rate of recurrence of PCP (more than 30 percent within 1 year).

Trimethoprim-sulfamethoxazole (TMP-SMX) (Bactrim DS, Septra) is the most effective anti-PCP prophylaxis regimen (Gallant et al., 1994). The minimum effective dose of TMP-SMX is not

known with certainty. A single daily dose of one double-strength tablet (160 mg of TMP and 800 mg of SMX) is most commonly prescribed.

It is recommended that all patients with CD4+ counts of 200 or below receive ongoing PCP prophylaxis. Anyone who has already had PCP, regardless of CD4+ cell count, should receive prophylaxis.

A regimen of one double-strength tablet three times per week has also been recommended as adequate. Given concerns about adherence, however, many clinicians continue to recommend daily dosing. A daily single-strength tablet (80 mg of TMP and 400 mg of SMX) may also be effective (Schneider et al., 1992).

The incidence of PCP falls to less than 5 percent per year in patients who comply with this prophylactic regimen. Interesting preliminary data suggest that the incidence of both cerebral toxoplasmosis and pyogenic bacterial infections may also be decreased in persons taking TMP-SMX for PCP prophylaxis. This latter observation may be especially important for HIV-infected AOD users who are at high risk for bacterial pneumonia and endocarditis.

For patients unable to tolerate TMP-SMX, **dapsone** (a drug used in the treatment of leprosy) is a reasonable alternative. Because dapsone can cause hemolytic anemia in patients (especially people of African descent) who are deficient in the enzyme glucose 6-phosphate dehydrogenase (G6PD), patients must be screened for this deficiency before beginning therapy.

The minimal effective dose of dapsone is unknown; regimens of 50 mg per day, 100 mg per day, and 100 mg three times per week are common.

Aerosolized **pentamidine**, delivered through the RespirGard II nebulizer in a single dose of 300 mg per month, is another option for PCP prophylaxis. The advantages of aerosolized pentamidine are that it has little if any systemic toxicity, and it may be the only agent a patient can tolerate. However, it is clearly inferior to TMP-SMX.

Breakthrough rates of PCP in patients on pentamidine may exceed 15 percent a year. In addition, the syndrome of extrapulmonary pneumocystosis has been described in which patients show evidence of PCP infection outside the lung. These manifestations can be expected to occur more commonly in patients receiving only inhaled pentamidine rather than systemic prophylaxis with TMP-SMX or dapsone.

Pentamidine should be administered only in designated settings with adequate ventilation consistent with CDC standards. Not only can pentamidine administration produce bronchospasm and cough, but the induction of coughing has been associated with the transmission of TB in inadequately ventilated settings. Some AOD treatment programs offering onsite aerosolized pentamidine have used specially designed sputum induction and pentamidine administration booths equipped with strong exhaust systems and high-efficiency particulate air (HEPA) filters to decrease the risk of contamination.

Side effects. TMP-SMX as a single daily tablet is well tolerated, with a low incidence of side effects. However, patients with HIV infection have a higher risk of allergy to sulfonamides than other patient populations and need to be monitored for adverse effects. Side effects, which tend to be dose related, may include rash, leukopenia, nausea and vomiting, liver function abnormalities, and fever. Serious reactions such as Stevens-Johnson syndrome, mucous membrane ulceration, hepatitis, and serum sickness are infrequent but potentially serious.

Patients on **dapsone** may experience rash, gastrointestinal upset, and anemia. Less common side effects include mental status changes and peripheral neuropathy. Sulfa allergy is generally not a contraindication to dapsone. Many patients who have developed rashes on TMP-SMX are able to tolerate dapsone without adverse effects; however, they should be monitored as part of routine followup.

Pregnancy. The current standard of care is to offer a pregnant woman PCP prophylaxis if she would be so treated if not pregnant (for example, CD4+ count < 200, or preexisting HIV-related disease). Although the treatment's possible risks or benefits to the fetus are uncertain, it has become standard to use TMP-SMX until 36 weeks gestation and then change to aerosolized

pentamidine to prevent neonatal exposure to sulfonamides (which can cause jaundice in the newborn).

Toxoplasmosis. Cerebral toxoplasmosis, another common opportunistic infection in patients with AIDS, occurs most commonly in people who have previously had a positive antitoxoplasma antibody test. Serologic testing for toxoplasma antibody is recommended as part of the basic primary care approach to HIV infection, in order to detect patients at high risk of development of this complication.

A positive antitoxoplasma antibody test is an indication to consider toxoplasmosis prophylaxis, especially in patients with CD4+ counts below 200 and/or a history of HIV symptomatic disease. Patients with a history of toxoplasmic encephalitis and other diseases from toxoplasmosis are maintained on chronic suppressive therapy with **sulfadiazine** and **pyrimethamine** plus folinic acid. Although not officially recommended, prophylaxis is appropriate for patients without prior disease who have latent infection with Toxoplasma gondii as indicated by a positive serum antibody test.

No specific regimens have been universally approved for prophylaxis against toxoplasmosis. It has been observed in several studies that anti-PCP prophylaxis with **TMP-SMX** may also offer protection against the development of toxoplasmosis. For patients who are unable to tolerate TMP-SMX, it has been suggested that **dapsone** plus **pyrimethamine** may provide effective prophylaxis against toxoplasmosis as well as against PCP (Girard et al., 1993).

Serologic testing for toxoplasma antibody is recommended as part of the basic primary care approach to HIV infection.

Mycobacterium avium complex. Patients with AIDS are also at risk for infection with atypical mycobacteria, especially Mycobacterium avium complex (MAC). This is a late-stage complication of HIV disease that generally occurs in its disseminated form (for example, in the blood) only in patients with a CD4+ count of less than 50. As patients survive for longer periods with low CD4+ counts, prevention and treatment of this common complication will be increasingly important.

The rifampin-like drug **rifabutin** is approved for prophylaxis against disseminated MAC infection in patients with fewer than 100 CD4+ cells. At a dose of 300 mg per day, rifabutin was demonstrated in two clinical trials to protect against the development of bacteremia from MAC (Nightingale et al., 1993; CDC, 1993).

However, clinicians must be aware that rifabutin may cause adverse interactions with other HIV disease medications, including **fluconazole** and **clarithromycin.**

It is not known with certainty whether rifabutin, like rifampin, causes accelerated metabolism of methadone; as a result, caution should be exercised in prescribing rifabutin to methadone-maintained patients.

Because of the potential for adverse drug interactions with rifabutin, clinical approaches to MAC prophylaxis vary. Some clinicians opt to wait until the CD4+ count drops to 50 before initiating prophylaxis. Others choose not to pursue prophylaxis, using the rationale that the disease is generally treatable (although treatment usually requires the use of three medications, and prophylaxis only one) and that patients should not be unnecessarily exposed to drug toxicity.

Another possible rationale for not pursuing MAC prophylaxis is that the use of a rifampin-like drug may promote the emergence of rifampin-resistant M. tuberculosis, especially in TB-endemic areas. Active TB should be ruled out in all patients taking rifabutin.

Clarithromycin and azithromycin, the two new macrolide antibiotics that are useful in the treatment of disseminated MAC, may also have a role in MAC prophylaxis. As of early 1995, however, these drugs were still being studied in clinical trials for this indication. There is currently no official recommendation for their use as prophylactic agents.

Cryptococcosis. Cryptococcal meningitis is a relatively infrequent complication of HIV infection, although it is one of the more common AIDS-defining opportunistic infections of the central nervous system. The treatment of cryptococcal meningitis has been greatly aided in recent years by the introduction of new systemic triazole antifungal medications such as **fluconazole** and **itraconazole.** These agents have made it possible to shorten the initial course of intravenous

therapy with **amphotericin B** for crytococcosis and certain other systemic fungal infections (for example, histoplasmosis) and have allowed chronic suppressive therapy with oral agents that do not require chronic intravenous administration.

Although it has been observed that patients receiving **fluconazole** may be less likely to develop cryptococcosis, it has been suggested that because cryptococcosis is not a common infection (occurring in fewer than 10 percent of patients with AIDS), routine prophylaxis is not cost effective.

There is a risk that routine prophylaxis of cryptococcosis would promote the development of resistant organisms, including resistant candida and other fungal species. In addition, in parts of the country where histoplasmosis and coccidioidomycosis are more common fungal complications of AIDS, the use of fluconazole has not been associated with decreased risk of occurrence of these infections.

Herpes simplex virus and cytomegalovirus. HIV-infected patients with recurrent genital HSV infection (and, less commonly, recurrent infection at other sites) should receive chronic prophylaxis with **acyclovir** (generally from 800 to 2,400 mg daily in two or three doses), as might be done in patients without HIV infection.

The likelihood of recurrent HSV infection increases with a declining CD4+ count. There is no strict threshold for the initiation of prophylaxis. Recent evidence suggests that acyclovir taken together with antiretroviral therapy may confer a survival benefit in late-stage AIDS patients (Stein et al., 1994; Youle et al., 1994).

There has been much recent interest in potential prophylactic agents against cytomegalovirus (CMV), which, like MAC, has been an increasingly common finding in patients surviving for longer periods of time at very low CD4+ counts. CMV most commonly causes retinitis, which can lead to blindness if untreated, and may also cause gastrointestinal, adrenal, pulmonary, and other systemic disease. At present, however, there are no clinically available options for primary prevention of this complication.

Currently, the only treatment options for CMV are intravenous **gancyclovir** or intravenous **foscarnet;** these agents must be continued indefinitely as suppressive therapy following initial treatment. Clinical trials **valacyclovir**, are under way an acyclovir-like oral agent that may offer some prophylactic benefit against the development of CMV disease, as well as an oral form of **gancyclovir**, which has shown promise in preliminary trials as a prophylactic against CMV.

Other HIV-Related Diseases in AOD Users

AOD users are at risk for a somewhat different spectrum of HIV-related disease than other HIV-infected populations. The following box summarizes the clinical spectrum of HIV-related disease and complications of drug use. The following description of conditions that clinicians are likely to encounter in treating an HIV-infected AOD abuse population is adapted from two articles describing treatment for this population (Selwyn and O'Connor, 1992; O'Connor et al., 1994).

Bacterial Infections. Bacterial pneumonia and **sepsis** were clearly described in IDUs before the AIDS epidemic, but they have been found to occur more frequently in HIV-infected AOD users. Bacterial pneumonia in this population is most often caused by *Streptococcus pneumonia* and *Hemophilus influenzae.* Both bacterial pneumonia and related bacteremia in HIV-infected AOD abusers tend to occur first in the earlier stages of immunosuppression and to be predictors of subsequent HIV-related illness in previously asymptomatic patients.

CDC currently recommends offering the pneumococcal polysaccharide vaccine to all HIV-infected patients. This vaccine is of questionable efficacy in patients with severely weakened immune systems, but it has been found to provide moderate immunity when given in the earlier stages of HIV infection. *H. influenza* vaccine may also be considered in HIV-infected patients, who are at increased risk for *H. influenzae* pneumonia.

Bacterial endocarditis is a well-recognized complication of injection drug use. Several studies have suggested that HIV infection may aggravate the frequency and severity of endocarditis, while others have shown a similar course in HIV-seropositive and HIV-seronegative drug uses with endocarditis. Active IDUs are also at risk for a variety of serious bacterial infections

involving the skin, soft tissues, bones, joints, central and peripheral nervous systems, and other anatomical sites. Proper needle hygiene and skin disinfection prior to drug injection may help prevent some of these complications of nonsterile needle use.

Tuberculosis. (See above, pages 39-42.)

Sexually transmitted diseases. STDs are common in AOD abusers, particularly among women involved in commercial sex work or the exchange of sex for drugs. Users of cocaine (especially "crack") have also been found to be at increased risk of STDs.

Baseline assessment should include taking the patient's **history of STDs** and involvement in sex-for-sale or sex-for-drugs transactions. Inspection for **genital and perianal lesions** should be part of the baseline physical examination. Serologic testing for **syphilis** (including both treponomal and nontreponomal tests, for example, VDRL and FTA-Abs) should be included in the initial laboratory testing screen.

Female AOD users should be offered a complete **pelvic examination** and testing for gonorrhea, chlamydia, and herpes simplex virus (as well as **Pap smears** at least annually because of the women's increased risk of cervical cancer). (See section on Women's Health Issues below.)

Incidence of syphilis. Between 1985 and 1990, the reported incidence of primary and secondary syphilis in the United States increased by more than 75 percent, with more than 50,000 cases being reported. A large proportion of the increase was attributable to substance use, especially the use of crack cocaine.

Treatment of syphilis. HIV-infected patients with primary and secondary syphilis should receive at least one intramuscular injection of **benzathine penicillin** (at least 2.4 million units). Multiple weekly doses of benzathine penicillin (up to a total of 7.2 million units), or treatment with supplemental antibiotics (**amoxicillin or ampicillin** with or without **probenecid**) may be advisable in some cases.

CDC recommends that, prior to treatment, HIV-infected patients with latent syphilis undergo lumbar puncture and cerebrospinal fluid (CSF) examination to rule out neurosyphilis. Patients whose CSF test results are normal should receive three weekly intramuscular injections of benzathine penicillin (2.4 million units). Those with evidence of neurosyphilis should receive a more prolonged course of 10 to 14 days of intravenous **penicillin**.

Clinicians treating HIV-infected AOD abusers with latent syphilis may encounter practical difficulties in trying routinely to follow the recommendation above for lumbar puncture. It is logistically difficult to perform lumbar puncture in the setting of an AOD treatment program, and asymptomatic patients are often unwilling to undergo the procedure.

Some alternative approaches, while not formally recommended, may be more practical for treatment of an HIV-infected AOD abuse population:

- Treat all latent-syphilis HIV-infected patients
- Reserve lumbar puncture and CSF examination for patients who have neurological complications or whose followup serologic tests do not indicate a clear response to antibiotic therapy.
- Have a low threshold to refer patients aggressively for further diagnostic workup or treatment as indicated.

For further guidance on treatment of STDs, please refer to *Sexually Transmitted Diseases Treatment Guidelines* (CDC, 1993e).

Hepatitis. Evidence of infection with hepatitis B virus (HBV) and hepatitis C virus (HCV) has been found in more than two-thirds of long-term IDUs (Donahue et al., 1991; Esteban et al., 1989; Stimmel et al., 1975). Chronic AOD users are also at increased risk for infection with hepatitis A virus (HAV) and hepatitis delta virus (HDV), which coexists with HBV. Underlying liver disease in AOD abusers may complicate the diagnosis of liver-function abnormalities and aggravate the liver toxicity of medications used to treat HIV infection, including **TMP-SMX, pentamidine, dapsone, rifampin, INH, didanosine**, and **zalcitabine** (O'Connor et al., 1994).

There is no consistent evidence that coexisting chronic hepatitis B infection adversely affects the course of HIV disease or, conversely, that HIV disease adversely affects coexisting HBV infection. However, individuals who are coinfected with HIV and HBV may have higher blood levels of HBV than individuals who are not HIV infected. Consequently, these coinfected individuals may be at higher risk of transmitting HBV infection.

CDC recommends that all susceptible HIV-infected individuals and the healthcare workers who provide their care should receive the HBV vaccine. A complete HBV serologic profile should be part of the baseline assessment of all AOD abusers with or at risk for HIV infection; patients found to be negative for HBV antibody markers should be considered eligible for HBV vaccine.

See Quick Reference Summary on the screening and prevention of infectious disease.

Nervous system disease. Clinicians caring for HIV-infected patients must frequently assess patients for altered mental status and other neurologic and neuropsychiatric syndromes. Differential diagnosis in such patients may include HIV-related dementia or encephalopathy, specific opportunistic infections affecting the central nervous system, metabolic or toxic encephalopathy, and the effects of substance abuse.

Underlying neurologic conditions associated with AOD use can obscure or complicate the diagnosis of the varied causes of peripheral nervous system disease in HIV-infected patients.

HTLV-I and HTLV-II. These retroviruses are "cousins" of HIV. Human T-lymphotropic retrovirus type 1 (HTLV-I) has been associated with adult T-cell leukemia/lymphoma and with certain chronic degenerative neurologic diseases. HTLV-II is less clearly associated with specific disease outcomes.

In the United States, infection with HTLV-I and HTLV-II is concentrated among IDUs. Seroprevalence studies in the mid-1980s found that more than one-third of AOD users in selected groups sampled in the New York metropolitan area and in the southeastern United

States were infected with HTLV-I and/or II. (Current antibody tests cannot readily distinguish between the two viruses.)

Recent data suggest that most AOD users who are coinfected with HIV and HTLV-I and/or II in fact have HTLV-II (Khabazz et al., 1992). In at least one study, HTLV-II coinfection was associated with rapid progression of HIV disease in AOD users infected with both viruses (Page et al., 1991).

Clinicians caring for HIV-infected AOD abusers should suspect coexisting HTLV-I or HTLV-II infection and consider serologic testing in patients with degenerative neurologic disease, T-cell leukemias, or rapidly progressing HIV disease.

Malignancies. Three types of cancer -- Kaposi's sarcoma, malignant lymphoma including different subtypes, and cervical cancer -- are considered AIDS-defining conditions under the classification system for HIV infection and AIDS established by CDC in 1993.

Clinicians caring for HIV-infected AOD abusers should suspect coexisting HTLV-I or HTLV-II infection.

HIV-infected AOD abusers are at relatively low risk for Kaposi's sarcoma; however, malignant lymphomas have been documented in this population. Persistent generalized lymphadenopathy is common in HIV-infected patients and palpable lymphadenopathy is frequently seen in IDUs. Nevertheless, the presence of large (>2 cm), firm, tender, or rapidly growing lymph nodes in an HIV-infected IDU patient should always prompt further diagnostic evaluation.

Women who are current or former AOD users comprise approximately 50 percent of AIDS cases in women to date in the United States. Clinicians treating AOD-abusing women should therefore be particularly alert to the possibility of cervical cancer in this population.

In addition to these AIDS-defining cancers, other malignancies have been found to occur with greater

frequency in HIV-infected AOD abusers. These non-AIDS-defining cancers (reported in several case series and one population-based study) have included solid tumors of the lung, head and neck, and gastrointestinal tract. Lung tumors are the most common (O'Connor et al., 1994).

Although such malignancies are rare, and HIV infection as their cause is unproven, primary care providers should be aware that HIV-infected IDUs who also smoke and drink alcohol heavily may be at increased risk for these cancers.

Immunizations

The following is condensed from an article on preventive healthcare by Hecht and Jewett (1993).

CDC recommends that HIV infection be considered an indication for pneumococcal vaccination because of the markedly increased risk of pneumococcal pneumonia among HIV-infected patients. Vaccination against *H. influenzae* type B should also be considered because HIV-infected individuals, particularly IDUs, are at increased risk for *H. influenzae* pneumonia.

CDC recommends the influenza vaccine for all HIV-infected persons. Vaccination for influenza is potentially useful for two reasons:

- HIV-infected patients are known to be at increased risk of pulmonary infection with bacteria that commonly complicate influenza.
- Because symptoms of influenza may mimic those of opportunistic infections, a reduction in the incidence of influenza may prevent unnecessary diagnostic evaluations for other HIV-related conditions.

Persons providing care of HIV-infected individuals should also be advised to be vaccinated against influenza.

CDC recommends that all susceptible HIV-infected individuals and the healthcare workers who provide their care should receive the HBV vaccine. Patients with HIV infection, if they have not already been exposed to HBV, are at high risk of acquiring it. HIV-

infected individuals are at considerably greater risk than non-HIV-infected individuals of becoming chronic HBV carriers. Further, HIV-infected HBV carriers may be more infectious because they are likely to have higher blood levels of HBV. (See information under Laboratory Tests on pp. 31-34.)

All of the above-mentioned vaccines are more effective when administered early in the course of HIV infection. There is little evidence that they are harmful to HIV-infected persons.

Other immunizations. Few data exist on the safety or efficacy of vaccination of HIV-infected adults for diphtheria, tetanus, mumps, rubella, polio, and measles. Inactivated polio, diphtheria, and tetanus vaccines are likely to be safe. Because these infections may cause illness in patients with suppressed immune systems, vaccination appears warranted according to standard guidelines for their use in non-HIV-infected adults.

Vaccination with the live, attenuated mumps, rubella, and measles vaccines may pose a greater risk to HIV-infected persons, and the benefit is less certain. However, these vaccines are routinely used in HIV-infected children whose immune systems are not suppressed, and in recent years, the measles vaccine has been safely given to HIV-infected adults during local measles epidemics. Measles vaccination should be considered for HIV-infected AOD abusers at risk of contracting measles. (See Quick Reference Summary, Immunizations in HIV-Infected Patients.)

Women's Health Issues

Primary care providers should be aware that, in general, the incidence of gynecological disorders is likely to be higher among female substance abusers than among non-AOD-abusing women. Some disorders (such as STDs) result directly or indirectly from substance use, while others may result from lifestyle factors that influence the overall health status of women in this population, such as poverty and lack of regular medical care.

Candidiasis. HIV-infected women may have more frequent and severe vaginal candidiasis than women who are HIV negative. The risk of severe or refractory vaginal candidiasis increases with a declining CD4+ count. Less severe cases of candidiasis should be treated with antifungal

creams or suppositories. Severe or chronic cases may require treatment with systemic **fluconazole.**

Cervical abnormalities. HIV-infected women are at increased risk for cervical dysplasia and possible invasive cervical cancer. Human papillomavirus (HPV) infection is significant in HIV-infected women because of its association with cervical dysplasia and cancer. Since 1993, invasive cervical cancer has been considered an AIDS-defining condition. Women who are current or former AOD users comprise approximately 50 percent of AIDS cases in women to date in the United States. Clinicians treating AOD-abusing women should therefore be particularly alert to the possibility of cervical cancer in this population.

HIV-infected women should receive Pap tests at least annually. Every 6 months, Pap tests should be considered in HIV-infected women at particularly high risk for cervical cancer, such as women with low CD4+ counts and women who smoke. Facilities treating HIV- infected women must either provide Pap smears and gynecologic followup on site or have contractual arrangements for the provision of these services. The efficacy of routine colposcopy as an additional means of screening high-risk HIV-infected women for cervical pathology is under evaluation.

STDs. Treatment of sexually transmitted disease in AOD patients was discussed on page 47. For further guidance on treatment of STDs, please refer to *Sexually Transmitted Disease Treatment Guidelines* (CDC, 1993e).

HIV-infected women should receive Pap tests at least annually. In women at high risk, the tests should be administered every 6 months.

Pregnancy

The HIV status of an infant born to an HIV-infected mother may not be known with certainty for up to 18 months after birth. All infants will initially have a positive HIV antibody test because of the presence of maternal antibodies in their blood. However, only 20 to 30 percent of infants will be found on followup to be HIV-infected. New diagnostic techniques may soon be able to diagnose HIV infection in infants earlier than is currently possible.

This information must be shared with the HIV-infected pregnant woman; her options should be presented in a nondirective fashion that empowers her to make her own decision about whether to continue her pregnancy with optimal prenatal care or seek a termination.

NOTE: The 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule requires AOD programs to link pregnant patients with prenatal services. (See summary of block grant interim regulations in Appendix B.)

Zidovudine therapy in pregnancy. Recent data indicate that zidovudine therapy may have a key role in preventing perinatal transmission of HIV from mothers to infants. A double-blind, placebo-controlled trial conducted by the National Institutes of Health AIDS Clinical Trials Group (ACTG), in collaboration with French researchers, found that only 8 percent of infants born to women treated with zidovudine were infected with HIV, compared with 26 percent of infants born to women treated with a placebo (CDC, 1994).

Women entering the ACTG study were between 14 and 34 weeks pregnant and had CD4+ cell counts above 200 (median CD4+ counts were approximately 550 in both treatment and placebo groups). Preliminary results of a second study found a similar protective effect for zidovudine among infants born to women with CD4+ counts below 200 (Boyer et al., 1994).

Participants in the ACTG study received an average of 12 weeks of therapy (200 mg zidovudine 3 times a day). Their newborn babies also received zidovudine during an initial postnatal followup period. Zidovudine did not appear to result in significant toxicity or differences in obstetrical outcomes between the treatment and placebo groups.

While the long-term effects on fetuses and infants of intrauterine exposure to zidovudine are unknown, these data represent the first evidence that the medication can reduce the risk of perinatal transmission of HIV. **CDC now recommends that pregnant HIV-infected women receive zidovudine therapy.** Given the large number of childbearing women among patients in substance abuse treatment programs, these data indicate an immediate need for expanded HIV counseling, testing, and education for women who are pregnant or likely to become pregnant.

Women with Children

HIV-infected AOD-abusing women are frequently the sole care providers for young children. Issues such as child care and transportation often must be addressed to bring these women into medical care and ensure that they continue to receive care. The children of HIV-infected women may be HIV-infected themselves and may have complex care needs. It is important that their care be coordinated with that of their mothers.

For uninfected children of HIV-infected women, decisions concerning custody and guardianship may be necessary. (See box, Chapter 5 on Custody of Children of HIV-Infected Parents.)

Physical and Sexual Abuse

Because women AOD abusers are at higher than average risk of physical and sexual abuse, healthcare workers should inquire directly about these issues. Partner notification of a woman's HIV status needs to be considered sensitively, and healthcare workers should be aware that women may fear victimization by a sexual partner. (See section on Partner Notification in Chapter 7.)

The box on the next page provides a Quick Reference Summary of health issues for HIV-infected women with AOD abuse problems.

Nutrition in HIV-Infected AOD Abusers

Exhibit 3-11 Factors Hindering Food Consumption in (more...)

Exhibit 3-11 Factors Hindering Food Consumption in HIV-Infected Patients

Factors Hindering Food Consumption in HIV-Infected Patients

Problem	Intervention
Anorexia (poor appetite)	Small, frequent meals; calorie- and protein-dense foods; relaxation techniques before meals; appetite stimulants, e.g., megestrol acetate
Nausea	Cold, bland, dry foods
Vomiting	Liquid diet (temporarily). Eat when asymptomatic; antiemetics as needed.
Diarrhea	Use of bulking agents; fluid replacement
Early satiety	Small, frequent meals. Avoid liquids before meals.
Dysphagia (difficulty swallowing)	Soft, blenderized or pureed foods or baby foods as tolerated; calorie- and protein-dense supplements
Odynophagia (pain upon swallowing)	Same as for dysphagia, plus avoidance of foods that cause pain (soda bubbles, citrus, spicy, or rough-textured foods)
Difficult or painful chewing	Same as for dysphagia and odynophagia, plus sucralfate slurry or viscous lidocaine swish before meals

Source: New York State Department of Health AIDS Institute; adapted from Rakower and Galvin, 1989.

AOD abuse treatment personnel must be aware of the special nutritional needs of HIV-infected AOD abuse patients. They should also be familiar with guidelines concerning nutritional supplements and with interventions to address the causes of inadequate food consumption. (See

Exhibit 3-11 for a summary of factors that must be considered in relation to the patient's food consumption.) Patients who are losing weight and for whom nutritional supplements are inadequate or ineffective should be referred to an HIV specialist (Gorbach et al., 1993). Clinicians must recognize that the overwhelming concern of many active AOD abusers may be obtaining substances of abuse rather than food. In an AOD abuser infected with HIV, this priority can exacerbate nutritional problems.

Special Clinical Issues

Pain Management

Managing acute and chronic pain in HIV-infected AOD abuse patients can be a challenging clinical problem (Selwyn and O'Connor, 1992). Although providers may have well-founded concerns about potential drug-seeking behavior, these concerns may interfere with clinical judgment about the appropriateness of narcotic analgesics. Like other patients, AOD abusers are often undertreated for acute pain. Medication for pain control, including narcotics, should never be withheld merely because a patient has a history of AOD abuse. (See Quick Reference Summary on pain management in HIV-infected AOD abuse patients.)

Medication for pain control, including narcotics, should never be withheld merely because a patient has a history of AOD abuse.

As in all patients with pain, the provider's primary goal is to maximize comfort while minimizing side effects. Local measures (rest, heat, ice, analgesic rubs) should be used as a first line of pain treatment where appropriate. If these measures fail to adequately control the pain, a systematized pharmacologic approach is recommended. Initially, over-the-counter medications such as **aspirin, acetaminophen,** and **nonsteroidal anti-inflammatory agents** should be used, with dosages increased as needed.

If these medications prove inadequate for of their tolerance for narcotics, opiate addicts generally require higher doses of narcotic analgesia and more frequent dosing intervals for effective pain control. This is especially true for patients maintained on methadone.

Agents used for persistent neuropathic pain include anticonvulsants (**phenytoin, carbamazepine**); tricyclic antidepressants (**amitriptyline, desipramine**);and **clonazepam** (with caution regarding its abuse potential). These agents may be used alone or in combination with other analgesics. Acupuncture may be particularly helpful in some cases of neuropathic pain.

The treatment plan and the reason for using narcotics for pain control must be clear to both provider and patient when analgesic therapy for acute pain is initiated. It is important not only that patients feel their pain is taken seriously, but also that narcotic use not be extended beyond a time-limited period required for analgesia. (An exception to this general principal may be evaluated in late-stage patients with AIDS who may have chronic, severe pain syndromes requiring ongoing analgesia).

Chronic pain management in AOD abuse patients is most effective in a setting of close primary care followup and coordination of a treatment plan with substance abuse treatment professionals. Pain management specialists should be consulted as needed to examine alternative management strategies (Selwyn and O'Connor, 1992).

Reducing the risk of medication abuse. Setting clear limits and devising a consistent treatment plan help reduce the risk of medication abuse by AOD-abusing patients. The following strategies are recommended:

- Designate one care provider to dispense prescriptions for controlled drugs.
- Dispense limited amounts of controlled drugs (e.g., 1 week's supply or less).
- Advise patients that lost or stolen prescriptions will not be replaced.

(See also Abuse of Psychiatric Medications, Chapter 4)

Special considerations in methadone-maintained patients. This above-mentioned agents may be used in patients maintained on methadone, but providers should be aware of their pharmacokinetic effects. (See next section and quick summary of pharmacologic interactions,

above.) Attempting to manage pain in methadone-maintained patients by increasing their daily dose of methadone is a common error. Instead, if narcotic analgesics are indicated, providers should continue the patient's usual methadone dose and add a shorter-acting narcotic for pain control.

Pentazocine and other mixed opiate agonist-antagonists should not be used for analgesia in methadone-maintained patients because they may precipitate withdrawal.

Pharmacologic Interactions

HIV infection does not change the indications for medication to treat AOD abuse. The most common medications used to treat substance abuse are **methadone**, **disulfiram**, and **naltrexone**. In addition, **benzodiazepines, barbiturates, clonidine hydrochloride,** and other medications are commonly used in detoxification. These medications can be used in HIV-infected AOD abuse patients the same way they are used in noninfected patients. The detoxification process need not be altered by the presence of HIV infection.

Interactions with methadone. The best-documented interaction between medications for substance abuse and those for HIV infection or related conditions is methadone/**rifampin,** used to treat tuberculosis or, less commonly, *M. avium* complex (Kreek et al., 1976). Rifampin causes more rapid breakdown of methadone in the liver and more rapid elimination of methadone in general, lowering the plasma methadone level. This results in the rapid onset of classic opioid withdrawal symptoms, usually within several days of rifampin initiation.

- Dispense limited amounts of controlled drugs (for example, 1 week's supply or less).
- Advise patients that lost or stolen prescriptions will not be replaced. (See section, Abuse of Psychiatric Medications, in Chapter 4.)

Special considerations in methadone-maintained patients. The above-mentioned agents may be used in patients maintained on methadone, but providers should be aware of their pharmacokinetic effects. (See next section and Quick Reference Summary of pharmacologic

interactions.) Attempting to manage pain in methadone-maintained patients by increasing their daily dose of methadone is a common error. Instead, if narcotic analgesics are indicated, providers should continue the patient's usual methadone dose and add a shorter-acting narcotic for pain control.

Pentazocine and other mixed opiate agonist-antagonists should *not* be used for analgesia in methadone-maintained patients because they may precipitate withdrawal.

Increasing patients' daily methadone doses will prevent this outcome. Typically, the dosage is increased by 10 mg every 1 to 2 days, beginning on the day rifampin is started and increasing as needed to prevent symptoms of opioid withdrawal, titrated to prevent oversedation. It is often necessary to continue this pattern until the dosage is at least 50 percent greater than the original daily dose.

Phenytoin and **phenobarbital** have a similar but less dramatic effect on plasma methadone levels, causing opioid withdrawal symptoms over a period of days to weeks (Tong et al., 1981). Methadone dosage increases may be necessary but usually need not be as great or as rapid as is necessary when patients are given rifampin.

When therapy with rifampin or phenytoin is discontinued, methadone doses should in most cases gradually be lowered to avoid oversedation. Patients will usually arrive at a final stable dose higher than their original dosage level before the other medications were introduced (Selwyn and O'Connor, 1992).

Rifabutin is a medication structurally related to rifampin and is frequently used for prophylaxis and treatment of *M. avium* complex in HIV-infected patients (Nightingale et al., 1993). Rifabutin may have a similar pharmacologic interaction with opioids. One small study found that, unlike rifampin, rifabutin did not predictably result in accelerated metabolism or elimination of methadone in chronic opiate addicts (Sawyer et al., 1993). Definitive data are lacking, however, and clinicians should consider this possibility.

Interactions with zidovudine. No clinically significant interactions have been found between methadone or disulfiram and zidovudine. One study suggested, however, that elimination of zidovudine may be decreased in methadone-maintained patients compared with a control group not receiving methadone (Schwartz et al., 1992). However, this study found no evidence of worse clinical toxicity from zidovudine in the methadone-maintained group. Several studies confirm that zidovudine is well-tolerated in HIV-infected opiate addicts (Broers, 1994; Samet et al., 1992a; Samuels et al., 1990; Selwyn et al., 1989; Selwyn et al., 1993).

Interactions with other antiretroviral agents. Little information is currently available about the toxicity profiles of the newer HIV antiretroviral agents (**didanosine, zalcitabine,** and **stavudine**) in AOD abusers. Because of the high risk of underlying alcoholic liver disease, hepatitis B and/or C virus infection, and pancreatitis in AOD abusers, it is important that patients taking these newer agents be closely monitored and evaluated for additive toxicity (O'Connor et al., 1994).

Clinical Trials Enrollment

Good physician-patient relationships can foster patient participation in clinical trials. Ongoing efforts are needed to educate patients about the utility of clinical trials and to alleviate their longstanding suspicion of the medical profession. Clinicians must be aware that HIV-infected AOD abusers who are recovering in abstinence-based treatment programs may be reluctant to participate in clinical trials of nonapproved medications because such participation reminds them of taking illicit drugs. Recovering AOD abusers who are involved in abstinence-based treatment programs may not wish to take drugs of any kind.

Specific efforts should be made to incorporate more AOD abuse patients, women, and minorities into HIV clinical trials. All of these groups are currently underrepresented. Medical staff of AOD programs also should be educated about the importance of clinical trials.

To avoid conflicts of interest, *it is recommended that, as far as possible, the clinician responsible for the clinical trial not be the patient's primary care provider.* When a patient enters a trial,

mechanisms for followup of results must be established so that this information is available to AOD abuse treatment staff.

Management of Therapeutic Crises

HIV-infected AOD abuse patients are likely to experience crisis points in their HIV treatment that place them at increased risk for drug-seeking behavior or relapse. Events that may trigger such a crisis include:

- Confirmation of positive HIV status
- A drop in the CD4+ count
- The illness or death of a friend or loved one
- A bout of PCP or other serious HIV-related illness.

Patients facing crises need close monitoring and enhanced intervention strategies. An increased level of contact with established support systems is essential during these stressful times to avoid or mediate relapse. For example, when a patient is hospitalized for HIV treatment, it may be helpful to arrange visits from staff of the patient's AOD abuse treatment program.

When crises occur, patients may demand higher doses of psychotropic medication. Medical providers should anticipate such crises and engage their HIV-infected patients in appropriate relapse prevention planning.

When disclosing diagnostic test results, clinicians must be sensitive to patients' counseling needs. For example, it may be helpful to alert counseling staff when a patient is told that his or her CD4+ count has fallen. Clinics should refrain from disclosing HIV antibody test results on Fridays unless staff are available on weekends to deal with patients' anxiety. (See section on HIV Disease and Risk of Relapse in Chapter 4.)

Unapproved Medication Use and Use Of Alternative Therapies

In the face of a life-threatening, chronic illness in which optimal care is still undefined, many patients will seek out unapproved medications and alternative therapies. Care providers must be aware that many HIV-infected patients may not be adhering to prescribed regimens or may be taking additional prescribed or nonprescribed medications in an inappropriate or non-FDA-approved manner. Patients may also be involved in the use of alternative or complementary therapies (for example, acupuncture, meditation, and vitamin and herbal dietary supplements).

Clinicians have a responsibility to find out, in a nonjudgmental manner, what alternative or unapproved therapies patients are using and to obtain as much information as possible about these treatment modalities. This information should be shared with patients, emphasizing that the risks and benefits of these therapies cannot always be predicted.

Unsupervised antibiotic use, in particular, can complicate the diagnosis and treatment of bacterial infections in HIV-infected AOD abuse patients. Clinicians should inquire specifically about unsupervised antibiotic use because patients may not consider the information relevant to their medication or drug use histories unless they are asked about it (Selwyn and O'Connor, 1992).

The use of alternative or adjunctive therapies varies according to locale and cultural characteristics. Their use is generally less widespread among HIV-infected AOD abusers than among non-AOD-abusing HIV-positive individuals. Data support the use of some alternative therapies, but others have no proven benefits. Unless a therapy is known to be harmful, however, patients need not be discouraged from trying it. Certain alternative therapies (for example, acupuncture, meditation, and herbal teas) may actually play a very useful role in decreasing patients' reliance on or need for controlled substances, narcotic analgesics, sleeping medication, and so forth.

Clinicians should assess drug-using patients' compliance and responsibility in handling prescribed medications. Medications should be dispensed consistently, with clear limits set on drug-seeking behaviors (Selwyn and O'Connor, 1992). As noted above, in the discussion of pain management, special controls need to be placed on the prescription of medications with high abuse potential

(for example, narcotics, benzodiazapines), including explicit rules that medications reported lost or stolen will not be replaced, only small numbers of pills will be dispensed at one time, prescription refills will only be obtainable through one designated care provider, and so forth.

Exhibit 3-12 Alternative Therapies and Unapproved Medications

(more...)

Exhibit 3-12 lists uses of alternative therapies and unapproved medications of which clinicians caring for HIV-infected AOD abusers should be aware.

Infection Control Issues for AOD Abuse Treatment Programs

The AIDS epidemic poses a number of challenges for infection control policy and practice in substance abuse treatment programs. Effective institutional infection control is more relevant for preventing the transmission of TB than for preventing the spread of HIV, although the latter often has received a greater amount of attention.

Universal Precautions

Exhibit 3-13 Universal Precautions for AOD Programs

(more...)

Adherence to universal precautions for exposure to blood and body fluids—as recommended by CDC, the National Institute of Occupational Safety and Health (NIOSH), and a wide range of other associations and organizations -- has been well established as the necessary standard of practice for all settings in which exposure to blood and body fluids is a potential hazard. Substance abuse treatment programs should apply the same standards of universal precautions that are in place in hospitals and other healthcare facilities (CDC, 1988). (See Exhibit 3-13.)

Substance abuse treatment programs should apply the same standards of universal precautions that are in place in hospitals and other healthcare facilities. Programs should seek guidance on adhering to universal precautions from local public health authorities or infection control staff of an affiliated institution.

Programs should seek guidance on adhering to universal precautions from local public health authorities or infection control staff of an affiliated institution. In settings such as freestanding community-based treatment programs, safe disposal of infectious wastes may require a deviation from standard waste disposal practices.

TB Infection Control

Exhibit 3-14 TB Infection Control Precautions for AOD

(more...)

The transmission of HIV infection is highly unlikely within institutions such as healthcare facilities, residential facilities, correctional facilities, residences, and substance abuse treatment programs when universal precautions are observed. By contrast, transmission of TB (including MDR-TB) has been proven to occur in all of these settings. Both epidemiologic and molecular genetic studies have documented the transmission of TB among immunosuppressed contacts within these environments, with high attack rates and high mortality rates, especially for MDR-TB (Daley et al., 1992; Fischl et al., 1992b; CDC, 1991a). TB infection control precautions should be developed with the guidance of infection control experts from affiliated institutions or public health agencies. (See Exhibit 3-14.)

TB infection control precautions should be developed with the guidance of infection control experts from affiliated institutions or public health agencies.

Issues in Engagement and Adherence to Medical Care For AOD Abusers

Factors Influencing Adherence to Care

As noted in the introduction to this chapter, many barriers prevent HIV-infected AOD abusers from receiving appropriate, timely medical care. According to one study, HIV-infected IDUs tend to delay seeking treatment, but once in treatment their compliance is no worse than that of other HIV-infected patients (Broers et al., 1994). Another study showed that patients' belief in the efficacy of zidovudine therapy is positively associated with adherence to treatment (Samet et al., 1992a). This finding underscores the need to educate patients and include them in all aspects of the treatment process.

Primary care providers need to be aware that a patient's relapse into AOD use may result in noncompliance with medical care. It is important that linkages be maintained between primary care and substance abuse treatment providers so that primary care providers are aware of such relapses when they occur.

Techniques to aid compliance. Techniques developed for use in geriatric psychiatry may be helpful in achieving better compliance among HIV-infected patients. These methods include:

- Repetition of instructions
- Written protocols
- Support persons who reinforce the importance of keeping appointments and adhering to medication regimens
- Use of a timing device to ensure that medications are taken at the proper time
- Use of lists that patients can post on a mirror.

Supervised Therapy

Existing indications for supervised therapy that are already part of AOD abuse treatment need not be changed solely because of HIV infection. The need for supervision becomes more critical, however, with the additional diagnosis of TB in an HIV-infected AOD abuse patient. The possible emergence of MDR-TB in HIV-infected patients presents additional risks and complications. Close

monitoring (directly observed therapy) of TB patients is necessary to prevent the development of MDR-TB.

To improve patient adherence to medical care, AOD abuse treatment programs must enhance their ability to provide supervised therapy. This supervision is especially important for patients with TB, but it is also a significant issue for those patients receiving antiretroviral and PCP prophylactic regimens but who have difficulty following prescribed regimens because of problems such as homelessness, cognitive impairment, or lack of health insurance or money to obtain medications.

The dispensing of TB medications along with methadone at a methadone treatment program is an example of enhanced supervised therapy.

Medications such as prophylactic antibiotics may also be given on a daily observed basis for patients with cognitive impairment or disorganized lifestyles; this supervision is particularly useful for medications that can be given only once daily or less (for example, TMX-SMX, fluconazole, and dapsone). AOD abuse treatment programs, because of their relatively intense interaction with patients, are in a unique position to help deliver such medication-related services. Different models for supervised therapy can be effective and should be developed for specific AOD treatment settings.

Patient Empowerment

Adherence to medical care means more than simply taking medications as prescribed. The foremost challenge in providing HIV and AOD abuse treatment is engaging patients and empowering them to be active participants in their own care. Many HIV-infected AOD abuse patients may be deeply distrustful of medical providers. Some will refuse or resist treatment for fear that their HIV status will be disclosed.

Strict observance of patient confidentiality is an essential element of creating an atmosphere of trust in which patients can make the choices that are best for them. Encouraging patients to discuss their fears can help build trust between patients and providers. Patient education

facilitates patient engagement and empowerment, and empowerment results in better adherence to medical care.

The following list of elements of a comprehensive patient education program is adapted from *HIV-1 Guidelines for Chemical Dependency Treatment and Care Programs in Minnesota* (Minnesota Department of Human Services, 1992.) All AOD abuse patients, whether HIV-infected or not, should receive education about:

- The fundamentals of HIV and AIDS
- Strategies for personal risk reduction
- Relevant treatment program policies regarding HIV
- Confidentiality rules and expectations
- Benefits of HIV antibody testing
- Overview of local HIV resources, including hotlines.

Patients who are HIV infected, whether they are symptomatic or not, should receive education about:

- Their disease status, prognosis, and treatment options
- Available medical and social service resources and entitlements and how to obtain them.

Linkages with other patients facing similar problems through support groups can promote empowerment by helping individuals feel less isolated and overwhelmed by their problems. Specific strategies for empowering and engaging patients may include:

- Holding support group meetings at the AOD treatment facility
- Offering educational sessions for HIV-positive AOD abusers in HIV and AOD treatment settings.

Patient education facilitates patient engagement and empowerment, and empowerment results in better adherence to medical care.

Program and Policy Issues

Education of AOD Abuse Treatment Staff About HIV-Related Issues

Most primary care services for HIV patients are provided within established AOD abuse treatment systems. It is crucial, therefore, that AOD abuse treatment professionals understand HIV-related issues and integrate them into existing services. Cross-training, consultation, referral, and mutual inservice training agreements between the staffs of HIV primary care treatment programs and AOD treatment centers can help achieve this integration.

Under the 1993 substance abuse block grant interim rule, employees of AOD treatment services must receive continuing education; education about HIV meets this requirement. (See summary of block grant interim rule in Appendix B.)

- Healthcare staff at all levels who work with AOD abuse patients—from administrators to maintenance staff handling infected waste -- need education about HIV-related issues. The following list of elements of a comprehensive HIV education program for AOD program staff is adapted from *HIV-1 Guidelines for Chemical Dependency Treatment and Care Programs in Minnesota* (Minnesota Department of Human Services, 1992:
- Fundamentals of HIV and AIDS
- Strategies for personal risk reduction
- Infection control in the workplace
- Harm reduction and abstinence models of care
- Overview of laws regarding confidentiality and access to services
- Program policies and procedures regarding HIV
- Overview of resources available to HIV-infected individuals
- Strategies for engaging patients to become active participants in their care.

Clinicians working with HIV-infected AOD abuse patients need to know how to set personal limits without abandoning patients. All healthcare workers, especially those who are themselves recovering AOD users, should be aware of the possibility that they may develop strong emotional ties to patients, which can influence their clinical care decisions.

Provision of services and care related to TB should be emphasized in the education and training of nurses, who should be able to perform skin testing and read test results. In many facilities, the ratio of nurses to patients is low; resources are needed to improve it. Clinical staff need to be educated about the dangers of TB so that they understand the importance of preventive interventions.

Quality Assurance

The concept of continual quality improvement (CQI) involves the continual review of program components and service delivery to ensure that defined levels of service are met. Mechanisms must be in place to identify when service delivery falls short of targets so that adjustments can be made. It is particularly important to have a CQI system in place in settings such as AOD abuse treatment programs that have not previously been oriented toward providing care for HIV-infected patients.

The ability to offer TB screening and CD4+ monitoring, supervised TB and PCP prophylaxis therapies, antiretroviral therapy, and postreferral followup are necessary components of any program treating HIV-infected AOD abusers. Every program should have a mechanism to ensure that patients who are appropriate candidates for prophylactic therapies receive them; this mechanism should include thresholds that trigger evaluation of the system of care. For example, if fewer than 90 percent of patients who are appropriate candidates for PCP prophylaxis are receiving it, a system problem may exist that requires evaluation.

Additional personnel and resources are needed to properly implement CQI evaluation and adjustment of services. It is inappropriate to add CQI responsibilities to the job description of a

staff member who is already fully committed to other duties. The resources required to implement CQI will vary in different models of AOD abuse treatment.

It is inappropriate to add CQI responsibilities to the job description of a staff member who is already fully committed to other duties.

Footnotes

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. Advances in the treatment of HIV disease have occurred since the consensus panel was held. Accordingly, to make the TIP as valuable as possible to readers, Dr. Selwyn updated this chapter. Copies of the revised chapter were then reviewed and approved by members of the workgroup who drafted the original chapter at the consensus panel meeting. These steps were taken to ensure that the TIP remained a consensus document.

TIP 15: Chapter 4—Mental Health and Counseling Needs of HIV-Infected AOD Abusers

Alcohol and other drug (AOD) abusers, whether or not they are HIV-infected, are subject to higher rates of mental disorders than the rest of the population. The Epidemiologic Catchment Area study found that nearly 30 percent of AOD abusers living in the community had comorbid psychiatric disorders (Regier et al., 1990).

Other studies have shown higher rates of psychiatric disorders among AOD abusers in treatment programs. In some studies, the lifetime prevalence of such disorders is as high as 80 percent (Ross et al., 1988).

It is not clearly known what proportion of HIV-infected AOD abusers has psychiatric disorders. One recent study found that 79 percent of HIV-infected injection drug users (IDUs) in treatment required psychiatric consultation and 59 percent had psychiatric disorders other than AOD abuse. Forty-five percent of these patients had organic mental disorders such as cognitive impairment, organic anxiety disorders, and organic mood disorders (Batki et al., 1992).

Counselors working with HIV-infected AOD abusers should be aware of the variety of both HIV-induced and AOD-induced psychiatric symptoms that may be seen in these patients. It is also important to recognize that psychiatric symptoms may be caused by starting, stopping, or mixing medications used to treat HIV disease.

Counselors working with HIV-infected AOD abusers should be aware of the variety of both HIV-induced and AOD-induced psychiatric symptoms that may be seen in these patients. It is also important to recognize that psychiatric symptoms may be caused by starting, stopping, or mixing medications used to treat HIV disease.

Linkages Between AOD Treatment And Mental Health Services

Ideally, AOD abuse treatment programs that do not possess resources to adequately assess and treat mental illness onsite should have the capacity to rapidly refer patients to closely linked mental health services. It is helpful to have clearly identified lines of communication between AOD abuse treatment programs and mental health services to facilitate clinical interaction concerning patients with complex needs.

Most mental health programs are not adequately equipped to provide AOD treatment. The AOD abuse treatment program should therefore maintain contact with the patient and continue the patient's AOD treatment during and after the psychiatric referral. AOD treatment staff may need to help patients obtain transportation to the psychiatric referral site. Providing concrete assistance such as transportation may increase the likelihood of patients' success in following through on referrals to psychiatric services.

Because it may be difficult for any one clinician to address the complex mental health and counseling needs of HIV-infected AOD abusers, the care of these patients is likely to involve multiple providers. A coordinated, holistic approach should be taken to the multiple problems of this target population.

Common Mental Disorders in HIV-Infected AOD Abusers

In general, mental disorders that are of particular concern in HIV-infected AOD abusers may be divided into three broad categories:

- Alcohol and drug-induced mental disorders
- HIV-related mental disorders
- Medication-related disorders
- Pre-existing mental disorders.

Any given patient may fall into one or more of these categories. Common mental disorders among HIV-infected AOD abusers include the following. (Terms used are those found in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV].)

- **Adjustment Disorders.** Often characterized by anxious mood, these disorders tend to be time-limited (for example, 3 to 4 weeks) acute responses to acute stresses such as receiving news of HIV infection or increasing disease severity. Stages of adjustment to the stress of life-threatening HIV infection have been described as analogous to the stages of adjustment to other illnesses. These generally begin with a crisis and progress to acceptance of and adaptation to the stressor.
- **Insomnia.** This is a frequently seen problem that is often associated with some forms of AOD abuse such as stimulant intoxication or withdrawal from alcohol or other depressants. The incidence of insomnia also increases with the development of HIV disease (Wiegand et al., 1991).

- **Depressive disorders.** Depression is a common response to learning of HIV infection or becoming more ill. Depression can also exist with or precede substance abuse. Patients may also become depressed for prolonged periods of time after withdrawal from abuse of alcohol, opiates, stimulants, and other substances (Kanof et al., 1993).
- **Mania.** Mania is frequently seen in HIV patients. In one study, mania was seen in as many as 8 percent of patients in an HIV medical clinic. Mania can also be a complication of AOD abuse, particularly abuse of cocaine and other stimulants. It can be difficult to determine whether mania is AOD- or HIV-induced (Lyketsos et al., 1993; Mirin et al., 1988).
- **Dementia.** Dementia may be due to alcoholism, head trauma, and numerous other causes, in addition to HIV disease. Differentiating these dementias can be difficult. All forms of dementia can be present with cognitive, behavioral, and motor abnormalities. Neuropsychological examination is useful in helping to make the diagnosis of dementia.
- **Delirium.** Mental confusion associated with acute encephalopathy or delirium can stem from many sources, including infection, AOD intoxication or withdrawal, toxicity from medication, or metabolic disturbances.
- **Psychosis.** Psychotic symptoms may be seen in advanced HIV dementia or in delirium and can be difficult to differentiate from substance-induced hallucinations and delusions as in, for example, paranoid psychosis resulting from the use of "crack" cocaine.
- **Personality disorders.** The presence of antisocial personality disorder or borderline personality disorder often complicates AOD abuse treatment for the HIV-infected patient. Please see the TIP, *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse* for information regarding the interaction of personality disorders with AOD abuse treatment. HIV-infected AOD abusers have high rates of personality

disorders, particularly antisocial personality disorder. The management of these chronic disorders is generally similar in both HIV-infected and non-HIV-infected AOD abuse patients.

Common Mental Disorders Among HIV-Infected AOD Abusers

- Adjustment disorders
- Insomnia
- Depressive disorders
- Mania
- Dementia
- Delirium
- Psychosis
- Personality disorders.

Medication-related mental disorders. It is essential to be aware that psychiatric symptoms in HIV-infected AOD abusers may result from the use of prescription medication. For example, high doses of **zidovudine** (AZT) (greater than 600 mg per day) can produce anxiety, insomnia, or hyperactivity.

In cognitively impaired AOD abusers with late-stage HIV disease, memory and other cognitive functions may be worsened by combinations of medications, particularly central nervous system depressants such as **benzodiazepines** (for example, **diazepam** [Valium and other drugs]) and anticholinergic medications such as the **tricyclic antidepressants** (for example, **amitriptyline** [Elavil and others]).

Interventions. Both pharmacologic and psychotherapeutic interventions should be used in the treatment of mental disorders in HIV-infected AOD abuse patients. This chapter describes some of the basic interventions and notes particular concerns, risk factors, and other issues relevant to HIV-infected patients. The important role of support groups in counseling this patient population

is also discussed. Psychotherapy and support groups are also important parts of treatment for HIV-infected AOD-abusing patients who are *not* mentally ill.

Cultural Sensitivity

Therapeutic interventions related to patients' mental health must be sensitive to the culture and ethnicity of the patient population. Whenever possible, therapists and support group leaders should share the culture of their patients and should speak the same language or vernacular. Cultural compatibility between therapists and patients is important in creating an atmosphere of trust in which sensitive issues such as family support and group mores can be addressed.

Some individuals may have strong spiritual beliefs that differ from dominant cultural norms. If their cultural context is not understood, such beliefs may be labeled delusional. Generally, the clinician's best guide is the patient's immediate family or community context. If the patient's beliefs are consistent with his or her community or culture of origin, it is less likely that they are delusional (Perez-Arce et al., 1993.)

Some individuals may have strong spiritual beliefs that differ from dominant cultural norms. If their cultural context is not understood, such beliefs may be labeled delusional.

Importance of Case Management

The healthcare needs of HIV-infected AOD abusers with mental disorders are complex, and treatment may involve multiple providers from a variety of disciplines. Communication and coordination among physicians, counselors, and other practitioners involved in a patient's care are therefore essential. Case management may be a useful way of ensuring that such coordination occurs.

For example, patients may not always fully divulge to a treating physician that they have a history of psychiatric disorder or that they are already receiving psychotropic or analgesic medication from another medical provider. By facilitating communication among providers, a

case manager can help to ensure that all parties involved in the care of an individual patient are as fully informed as possible about the patient's treatment status.

A comprehensive treatment plan and an individualized risk reduction plan should be prepared and followed for each patient. Case management must be flexible so that patients receive more attention as their needs increase. (See Case Management section in Chapter 5.)

Assessment and Diagnosis

Exhibit 4-1 Initial Mental Health Assessment for the

(more...)

Exhibit 4-1 outlines the major categories of information necessary for a basic mental health assessment.

Assessment and diagnosis of mental illness in HIV-infected AOD abuse patients can present a daunting challenge because of these patients' complex problems. It is important to evaluate patients' behavior in context. For example, acute depression is relatively common among individuals who learn that they are HIV-positive. This type of time-limited adjustment disorder may lead to worsened AOD use. In turn, depression may be made more severe or prolonged by concurrent AOD abuse.

It can be difficult to determine whether AOD abuse preceded the psychiatric disorder or vice versa. AOD abuse may be an attempt at self-medication in response to an underlying psychiatric disorder. Although mental disorders may predate AOD abuse, generally the reverse is true.

Because an accurate and complete history cannot always be obtained from the patient, corroborative sources of information (such as the patient's family or a previous healthcare provider) are essential to a complete assessment.

History-taking. Counseling staff should begin the assessment of the HIV-infected AOD abuse patient by taking a psychosocial history that is as judgment free as possible and that includes open-ended questions. It is important that this questioning acknowledge and respect not only ethnic and cultural differences but also alternative sexual lifestyles.

A complete medical history focusing on HIV and AOD abuse should be taken at intake to AOD treatment. A recent physical examination and laboratory test results should be readily accessible because they may help in the assessment of the patient's counseling needs. For example, a CD4+ lymphocyte count ("T" cell count) below 200 informs the mental health or counseling professional that the patient is at higher risk for organic mental disorders such as HIV-related dementia.

Mental status examination. A comprehensive mental status examination is the key to detecting mental disorders. Among other things, this exam may reveal cognitive problems such as deficit memory. The cognitive portion of the mental status examination can be expedited by the use of standardized questionnaires such as the Mini Mental State Exam.

It is helpful to have a psychiatrist or psychologist perform the examination, but most nonpsychiatric physicians are familiar with the basic components of a brief mental status examination. Nursing staff and counselors can also be taught to administer screening examinations such as the Mini Mental State Exam.

A complete medical history focusing on HIV and AOD abuse should be taken at intake to AOD treatment.

A good screening instrument can assist clinicians in asking appropriate questions. In addition to the Mini Mental State Exam, other examinations, such as the Beck Depression Inventory, may be particularly useful in assessing the severity of depressive symptoms (Beck, 1993).

In addition to receiving an initial assessment of needs, HIV-infected patients should be periodically reassessed. Fluctuating health status and functional capacity will mean that clients'

needs change over time. Repeated mental status examination is also helpful when a change in cognitive or behavioral status is noted by AOD counselors or medical staff.

Treatment goals. It is essential to set realistic treatment goals that vary with the patient's functional capacity. For example, immediate abstinence from AODs may be too much to expect from severely psychiatrically disturbed AOD abusers, and AOD programs may need to have a flexible range of treatment goals for such patients. (See Dealing With Ongoing AOD Abuse, below.)

Dementia in HIV Disease

Neurocognitive impairment is a common complication of HIV disease. In its severe form it is known as AIDS dementia complex (ADC). This complication is one of the most challenging and anxiety-provoking manifestations of HIV disease for the patient and his or her family, as well as for the AOD treatment provider.

Neurocognitive impairment is one of the most challenging and anxiety-provoking manifestations of HIV disease for the patient and his or her family, as well as for the AOD treatment provider.

The diagnosis of dementia in the HIV-infected AOD abuser is based on the presence of significant and disabling impairment of functioning. Usually, impairment is present in three areas:

- Cognitive functioning (for example, memory disturbance),
- Behavioral functioning (for example, altered behavior such as agitation or psychosis)
- Motor functioning (for example, gait disturbance or incontinence).

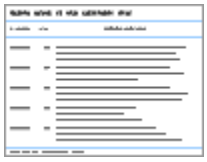

Exhibit 4-2 Abbreviated SFGH Neuropsychiatric AIDS (more...)

Exhibit 4-2 Abbreviated SFGH Neuropsychiatric AIDS Rating Scale (NARS) 1

Abbreviated SFGH Neuropsychiatric AIDS Rating Scale (NARS)[1]						
	Cognitive/Behavioral Domains					
NARS Staging	**Orientation**	**Memory**	**Motor**	**Behavioral**	**Problem Solving**	**Activities of Daily Living**
0 (Normal)	Fully oriented	Normal	Normal	Normal	Can solve everyday problems	Fully capable of self-care
.5 (Minor)	Fully oriented	Complains of memory problems	Fully ambulatory; slightly slowed movements	Normal	Has slight mental slowing	Slight impairment in business dealings
1 (Mild)	Fully oriented but may have brief periods of "spaciness"	Mild memory problems	Balance, coordination, and handwriting difficulties	More irritable, labile; or apathetic and withdrawn	Difficulty planning and completing work	Can do simple daily activities; may need prompting

2 (Moderate)	Some disorientation	Memory moderately impaired; new learning impaired	Ambulatory but may require a cane	Some impulsivity or agitated behavior	Severe impairment; poor social judgment; gets lost easily	Needs assistance with ADLs
3 (Severe)	Frequent disorientation	Severe memory loss;only fragments of memory remain	Ambulatory with assistance	May have an organic psychosis	Judgment very poor	Cannot live indepen-dently
4 (End Stage)	Confused and disoriented	Virtually no memory	Bedridden	Mute and unresponsive	No problem-solving ability	Nearly vegetative

The NARS was developed by A. Boccellari, Ph.D., J.W. Dilley, M.D., and I. Barlow, M.D., Department of Psychiatry, San Francisco General Hospital, in collaboration with S. Hernendez and B. Haskell, San Francisco Department of Public Health. The exhibit was adapted from Price and Brew, 1993; Hughes et al., 1982; and American Academy of Neurology, 1991.

Diagnosis requires neuropsychological evaluation employing a battery of neuropsychological tests. A diagnosis cannot reliably be made using a brief cognitive capacity examination such as

the Mini Mental State Exam. However, poor performance on a brief cognitive screen is an indication that dementia may be present and calls for further testing (see Exhibit 4-2).

HIV-related neurocognitive loss usually progresses gradually. Early signs and symptoms of neurocognitive impairment include

- Short-term memory loss (forgetting appointments, misplacing items, forgetting to take important medications)
- Loss of visual, spatial, and fine coordination (impaired handwriting, difficulty assembling objects or equipment)
- Cognitive slowing (taking longer to speak or to understand, appearing "slow" in interviews)
- Mood changes (mild apathy, depression, hyperactivity).

In later stages of dementia major impairments become obvious, such as

- Mutism or unresponsiveness to speech
- Agitation, hallucinations, paranoia or other delusions
- Severe neurological problems (incontinence, inability to walk).

The risk of dementia and other cognitive deficits is highest in HIV-infected patients who are severely immunocompromised. The CD4+ lymphocyte count ("T-cell count") is a useful index of an individual's risk for AIDS dementia. Generally, dementia is most likely to occur in patients with CD4+ counts below 200 (Boccellari et al., 1993a, 1993b).

Pharmacologic Treatment

Introduction

Standard pharmacologic approaches may be taken in the treatment of psychiatric disorders in HIV-infected AOD abuse patients, with some specific caveats. Without exception, a

medical/psychiatric diagnostic evaluation should always be carried out before medication is provided.

Some AOD abuse treatment staff may oppose the use of pharmacologic interventions in AOD abuse patients because of a concern that these medications may place patients at risk for relapse into substance abuse. While these concerns must be acknowledged, it is necessary to distinguish medications from drugs of abuse. An approach to care that does not permit the use of psychiatric medications when appropriate may deprive patients of the opportunity to benefit from a legitimate and necessary treatment option.

Without exception, a medical/psychiatric diagnostic evaluation should always be carried out before medication is provided.

Abuse of Psychiatric Medications

Exhibit 4-3 Abuse Potential of Common Psychiatric Medications (more...)

Exhibit 4-3 Abuse Potential of Common Psychiatric Medications

Abuse Potential of Common Psychiatric Medications		
MEDICATION CLASS	**ABUSABLE**	**NONABUSABLE**
Sleep medications	• Benzodiazepines: • Diazepam (Valium) • Flurazepam	Trazodone (Desyrel) Diphenhydramine (Benadryl) Hydroxyzine (Vistaril) Tricyclic antidepressants (TCAs)

	(Dalmane) • Chlordiazepoxide (Librium) • Clonazepam (Klonopin) and others • Chloral hydrate • Barbiturates • Meprobamate<	
Antianxiety	Benzodiazepines	Tricyclic antidepressants Buspirone (BuSpar)
Antidepressants	Methylphenidate (Ritalin) Dextroamphetamine	Fluoxetine (Prozac) and other serotonin reuptake inhibitors (SSRIs) TCAs Bupropion (Wellbutrin) Venlafaxine (Effexor) Nefazodone (Serzone)
Mood stabilizers	Clonazepam (Klonopin)	Lithium carbonate Carbamazepine (Tegretol) Sodium valproate (Depakote)
Antipsychotics	None	• All: • Chlorpromazine (Thorazine) • Thioridazine (Mellaril) • Haloperidol (Haldol) • Risperidone

		(Risperidol) etc.

Exhibit 4-3 lists abusable and nonabusable psychiatric medications.

In animal and human testing, most of the major classes of psychiatric medications have been proven *not* to have abuse potential. Examples are antipsychotic medications such as **chlorpromazine** (Thorazine), mood stabilizers such as **lithium**, and nonpsychostimulant antidepressants such as **fluoxetine** (Prozac).

On the other hand, two types of medications are known to have abuse potential:

- Central nervous system depressant, antianxiety, and anti-insomnia medications such as **diazepam** (Valium) and **chlordiazepoxide** (Librium)
- Psychostimulants such as **amphetamine** and **methylphenidate** (Ritalin).

When working with any AOD-abusing patient, it is reasonable to expect that some misuse of legally prescribed controlled substances may take place. A hierarchical approach to prescribing is recommended to minimize the potential for abuse of psychiatric medications.

A hierarchical approach to prescribing is recommended to minimize the potential for abuse of psychiatric medications.

In this approach, the least abusable medications are prescribed first and the most potentially abusable are used only when other agents have not been effective. Dispensing medication in small amounts (for example, 1 day or 1 week's supply) helps to limit the overuse, misuse, or abuse of potentially abusable medications.

HIV-infected persons may be more than usually sensitive to prescription medications as well as to drugs of abuse. When prescribing, clinicians should attempt to use the lowest effective dose to minimize side effects. With patients who have advanced HIV disease, it may be wise to start out with very low doses of the magnitude generally associated with geriatric psychiatry.

With patients who have advanced HIV disease, it may be wise to start out with very low doses of the magnitude generally associated with geriatric psychiatry.

Suicide. AOD abusers are at increased risk of suicide. HIV-infected individuals may also be at risk of suicide, especially if they are suffering from a mood disorder. Medication should be dispensed in small amounts (one week's supply or less) until a patient's level of responsibility can be fully assessed. Tricyclic antidepressants (TCAs) such as amitriptyline (Elavil) and others are especially likely to be lethal in overdose.

Abuse of intravenous infusion lines. Patients with advanced HIV disease are frequently prescribed narcotic analgesics and may have an indwelling intravenous line for infusion therapy. Clinical experience has shown that IDUs are at very high risk of using this indwelling intravenous line to administer heroin, cocaine, and other drugs of abuse. It is therefore essential that patients with such lines be cared for in residential settings where adequate monitoring and support can be provided.

Adverse Effects of Some Medications

- **Side effects.** As HIV infection progresses, some medications may cause adverse side effects in some patients.
- Medications whose anticholinergic effects block saliva flow cause dry mouth.
- For example, **tricyclic antidepressants** (TCAs) and **antipsychotics** can produce dry mouth and cause oral candidiasis and other mouth infections.
- Stimulation from **antidepressants** may trigger hyperactive or manic behavior, especially in the HIV-infected AOD abuser who may already have mild central nervous system impairment because of HIV.
- HIV-infected patients are more sensitive than others to movement disorders such as extrapyramidal symptoms (EPS) that can be caused by antipsychotic medications like **haloperidol** (Haldol).

- Central nervous system depressants such as sedative-hypnotics should be used with caution because they may cause confusion, memory impairment, and depression.

It is reasonable to suspect that any sudden behavior change or new physical symptom in a patient on medication may be medication related. With some medications, such as **lithium**, the TCAs (for example, **amitriptyline**), and certain antipsychotics (for example, **haloperidol**), blood levels should be tested periodically to avoid drug toxicity.

Adverse interactions. Clinicians must be aware of the potential for adverse interactions between HIV treatment medications and psychiatric medications. HIV-infected patients are often prescribed complex medication regimens. Medications, either alone or in various combinations, may cause confusion and other psychiatric symptoms.

For example, a patient may be prescribed **fluoxetine** (Prozac) for depression plus an antianxiety medication such as **lorazepam** (Ativan) and may also be receiving **zidovudine** and the antibiotic **trimethoprim-sulfamethaxazole** (Septra), as well as other medications.

In any individual patient it can be difficult to predict the outcome of interactions among so many medications.

Because of the potential for adverse interactions among medications, it is essential that medical and psychiatric care providers communicate with each other when treating an HIV-infected AOD-abuse patient (see Case Management section in Chapter 5).

Communication may also be significantly helped by the pharmacist who fills the patient's prescriptions. Pharmacists can play a role in educating patients and helping to reduce possible adverse effects of drug interactions. In addition, pharmacists are invaluable sources of information about what medications other healthcare providers may have prescribed to the patient.

It is essential that medical and psychiatric care providers communicate with each other when treating an HIV-infected AOD-abuse patient.

If a patient appears to be adversely affected by multiple medications, the AOD abuse treatment provider must report the observed physical or behavioral change to the patient's primary medical provider as soon as possible so the problem can be addressed.

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Exhibit 4-4 Use of Medications for Psychiatric Disorders (more...)

Exhibit 4-4 Use of Medications for Psychiatric Disorders In HIV-Infected AOD Abusers

Use of Medications for Psychiatric Disorders In HIV-Infected AOD Abusers A hierarchical or stepwise strategy should be followed in prescribing medications to HIV-infected AOD abusers. Low doses of safer and less abusable medications should be tried first, and higher doses or less safe agents used only if the initial approach is ineffective.
Insomnia/Sleep Disorders
When treating insomnia and sleep disorders in AOD/HIV abusers, choose an approach that minimizes abuse potential.

First Tier	Simple "sleep hygiene" aids such as a glass of warm milk, a warm bath, meditation, or soothing music are the first recommended

	ways to deal with insomnia.
Second Tier	1. **Trazodone** (Desyrel) is an antidepressant and sleeping medication with no known abuse potential and low adverse effects. Dosage can start at 25 to 50 mg at bedtime and increase as needed to 100 to 200 mg. **Side effects** include hypotension (low blood pressure) and very rarely priapism (persistent painful erection). (Priapism is extremely uncommon, occurring in less than 1 in 4,000 men taking trazodone.) 2. **Hydroxyzine** (Vistaril, Atarax) or **diphenhydramine** (Benadryl). Doses can start at 25 to 50 mg at bedtime and increase to 100 to 150 mg. These medications are generally not abusable, but they can cause **anticholinergic side effects**, such as dry mouth and lowering of the seizure threshold if given in very high doses (over 250 mg per day). 3. Tricyclic antidepressants (TCAs) such as **amitriptyline** (Elavil) or **doxepin** (Sinequan). Doses for sleep can start at 25 to 50 mg at bedtime. Numerous adverse effects (see **Mood Disorders** section of table, below). *Often lethal in overdose (amounts > 1 g [1,000 mg]).* 4. Sedating antipsychotic medications such as **chlorpromazine** (Thorazine) should be used *only* in the presence of psychotic or manic symptoms, *never* for insomnia alone.
Third Tier	If the medications listed above fail, a brief course of **benzodiazepines** should be considered, preferably on a short-

	term basis (ideally for less than 2 weeks). They should be moderately short acting, such as **temazepam** (Restoril) and **lorazepam** (Ativan), to minimize accumulation of medication and resultant sedation. Ultra-short-acting agents such as **triazolam** (Halcion) should be avoided because they may cause withdrawal psychosis and confusion, including memory loss. Be cautious when prescribing long-acting medications such as **diazepam** (Valium) because of their cumulative effects. **Flurazepam** (Dalmane) also can have cumulative effects and may cause morning confusion ("hangover"). Caution is also urged with **alprazolam** (Xanax), which may be more abusable than other benzodiazepines.
Anxiety	
First Tier	Alternatives to pharmacologic intervention include relaxation techniques, meditation, supportive psychotherapy, or counseling, as well as stress management and reduction and possibly acupuncture. Some of these approaches should be tried before medications are introduced.
Second Tier	1. TCAs such as **imipramine** (Tofranil) are alternatives to potentially dependence-producing agents like the benzodiazepines. 2. **Buspirone** (BuSpar) is another nonabusable medication for chronic anxiety. *Patients must be warned that it is usually necessary to take either buspirone or the TCAs for at least 2 weeks before antianxiety effects are felt.*
Third Tier	See third-tier section of insomnia/sleep disorders above with the same cautions for the use of benzodiazepines: Choose relatively short-acting medications for limited-time use and at limited dosages. Other possible alternatives to the benzodiazapines for

	anxiety disorders are beta blockers such as **propranolol** (Inderal) and the antihypertensive agent **clonidine**. However, clonidine may pose a danger of overdose and should be dispensed in limited amounts (for example, 1 week's supply). **Hydroxyzine** (Vistaril, Atarax) can also be used in doses of 25-50 mg in the daytime as needed as an antianxiety agent, although it is highly sedating. *Antipsychotics should not be used to treat anxiety if there is no evidence of psychosis, mania, or severe dementia.*
Panic Attacks	
First Tier	A nonbenzodiazepine medication such as a TCA, e.g., **desipramine**. Dosage should be in the same range that would be used to treat depression, with a more gradual increase over 1 to 2 weeks from 25 mg at bedtime to 150 mg at bedtime. Response takes 2 to 4 weeks. TCAs have numerous, moderately troublesome **side effects** (see **Mood Disorders** section, below). *TCAs can be lethal in overdose (amounts > 1 g [1,000 mg]).*
Second Tier	If TCAs are ineffective, too risky, or not tolerable because of adverse effects, benzodiazepines should be used. **Alprazolam** (Xanax) is probably used most frequently. Any benzodiazepine is likely to be effective when used in divided doses totaling approximately 10 to 60 mg per day of **diazepam** (Valium) or its equivalents. (See **Insomnia/Sleep Disorders** section for risks of benzodiazepine use.)
Mood Disorders*Major Depressive Disorders*	
First Tier	The initial approach should include supportive psychotherapy (individual or group) and possibly peer-based supportive counseling. If these approaches fail, however, pharmacologic interventions should be made readily available to the AOD/HIV patient. *A careful evaluation must always be done before*

	medications are prescribed. Mood disorder patients are at risk of suicide.
Second Tier	The serotonin reuptake inhibitor (SSRI) antidepressants--**fluoxetine** (Prozac), 20 mg per day; **sertraline** (Zoloft), 100 to 200 mg per day; and **paroxetine** (Paxil), 20 to 50 mg per day, are all safe and effective. They tend to be nonsedating and are generally safe even in overdoses. They are usually the most tolerable antidepressants. **Side effects** in 10 to 20 percent of patients may include jitteriness, insomnia, muscle tightness or twitching, mild appetite loss, and mild gastrointestinal illness, as well as some loss of sexual interest and delayed orgasm or ejaculation. **Trazodone** (Desyrel) is also extremely safe but its sedating properties limit its usefulness. Patients can rarely take it in large enough doses or in the divided doses necessary for antidepressant effectiveness. However, it can be very useful as a sleeping medication. **Bupropion** (Wellbutrin) is another non-TCA that is generally safer in overdose than the TCAs. It is more complicated to use than the SSRIs because it must be given in three divided doses totalling 225 to 450 mg per day. **Bupropion** tends to increase the risk of seizures more than other antidepressants. Other **side effects** include jitteriness and insomnia. There is a lower incidence of sexual adverse effects with bupropion than with other antidepressants.
Third Tier	**TCAs** are not addictive, but they have a number of troublesome **side effects**, including dry mouth and short-term memory loss. Other side effects--blurry vision, constipation, tremor, and low blood pressure--may contribute to falls, weight gain, and oversedation. Side effects may be offset by low dosages. HIV-infected patients may be more sensitive to side effects. AOD-

	abusing patients may be more likely to request TCAs that have sedating effects, such as **doxepin** (Sinequan) and **amitriptyline** (Elavil). *All of the TCAs are lethal in overdose and should not be given to unmonitored suicidal patients.*
Fourth Tier	**Psychostimulants** may be useful for late-stage AIDS patients with severe psychomotor retardation (Fernandez, 1990). Some dramatic, rapid improvement has been observed. **Methylphenidate** (Ritalin) is the safest and easiest to manage of the psychostimulants. Methylphenidate and amphetamines such as **dextroamphetamine** should not be used until other medications have failed, but they should not be withheld solely because of a patient's AOD abuse history. Psychostimulants should be administered early in the day and monitored carefully because they cause insomnia. If prescribed to an outpatient, daily dispensing is recommended. If this is impractical, prescriptions should be written for limited quantities and compliance closely monitored. Other side effects of psychostimulants include jitteriness, agitation, delusions, hallucinations, and anorexia, as well as abuse and dependence. ***Monoamine oxidase*** *(MAO) inhibitors should be avoided unless all other treatments fail.* Use of these medications requires dietary restrictions and carries the potential for lethal hypertensive interactions with other drugs.

Bipolar Disorder

Evaluation of the AOD abuser with mania must include a high level of suspicion that the disorder is caused by abuse of substances such as stimulants. **Lithium** is as effective in the AOD/HIV patient as in the general population in treating mania in bipolar disorders. It is nonabusable but must be monitored carefully because of **side effects**, which include dehydration, diarrhea, and altered mental state. Other adverse effects of lithium include

tremor, excessive thirst, frequent urination, and weight gain. The anticonvulsant medication **carbamazepine** (Tegretol) is also useful but it can cause severe neutropenia (bone marrow suppression). This may be dangerous when combined with **zidovudine** (AZT), which has a similar adverse effect. In patients maintained on methadone, carbamazepine may induce liver enzymes that can metabolize methadone more rapidly than normal and lead to opiate withdrawal symptoms which may necessitate higher doses of methadone. **Sodium valproate** (Depakote) is another alternative to lithium. It avoids the problems of carbamazepine and may be safer but is less proven as a mood stabilizer.

Psychosis/Severe Manic States

Psychosis is frequently caused by AOD use such as "crack" cocaine intoxication or alcohol withdrawal. AOD use should always be evaluated thoroughly before prescribing. Antipsychotic medications are nonaddictive and can be used effectively to treat both acute mania and psychosis. The lowest possible effective dosage should be used, with side effects closely monitored, and the patient should be frequently reevaluated. Abuse of antipsychotic medications, even by AOD abusers, is rare. Antipsychotic medications include **haloperidol** (Haldol), **chlorpromazine** (Thorazine), **thioridazine** (Mellaril), **trifluoperazine** (Stelazine), and many others. These medications are also occasionally used for the management of agitated confusional states, such as in late-stage dementia. **Clozapine** (Clozaril) should probably be avoided in most HIV-infected patients because it can cause profound reduction of bone marrow and blood cell production in 1 to 2 percent of patients. Some patients develop **extrapyramidal side effects** (EPS)-involuntary muscle spasms, jerking, muscle stiffness, or tremor-from antipsychotic medications. **Diphenhydramine** (Benadryl) and other medications can be used to counter EPS, but these agents can produce **anticholinergic side effects** such as dry mouth, agitation, and confusional

states. An alternative medication to treat EPS may be **amantadine** (Symmetrel). High-potency antipsychotic medications that have the fewest sedating or anticholinergic adverse effects, such as **haloperidol**, may have the most EPS side effects. EPS may be more severe in HIV-infected patients than in otherwise healthy patients with psychoses. Other adverse effects of antipsychotic medications include oversedation, low blood pressure, constipation, dry mouth, and blurry vision.

Dementia

A thorough medical evaluation of confusional states and cognitive decline in the demented patient should precede the use of psychiatric medications. Treatment for HIV infection, including zidovudine (AZT) and other antiretroviral medications, may lead to improvement in dementia. Coping techniques such as those used in the treatment of Alzheimer's disease may increase adherence to treatment regimens among patients with HIV-associated cognitive and motor complex. For example, patients should be encouraged to keep appointment books. Stable housing can increase patients' likelihood of keeping scheduled appointments and taking medications. Frequent reminders, notes, and other memory aids can help. **Stimulants** are sometimes helpful in treating depression accompanying dementia, especially in cases of severe psychomotor retardation. (See discussion above of fourth-tier mood disorders.) Low doses of high-potency antipsychotic medications such as **haloperidol** may be helpful in controlling agitated behavior accompanying dementia. **Benzodiazepines** and other sedating medications should be avoided if possible because they can cause further confusion, memory impairment, and depression.

Exhibit 4-4 offers a brief guide to appropriate pharmacologic therapy for patients with HIV/AIDS and chemical dependency. (See also Pharmacologic Interactions section in Chapter 3.)

Counseling

Introduction

Counseling is an important part of treatment for all AOD abusers, including those with comorbid psychiatric disorders. The goal of counseling is to help HIV-infected AOD abusers maintain health, achieve recovery from AOD abuse, and attain the best possible level of psychological functioning. Counseling may be done individually, in groups, or with patients' families.

Exhibit 4-5 Stages of Recovery

Counselors need to be aware that patients are likely to move through different stages in the course of both AOD abuse and HIV disease. Part of the counselor's role is to help the patient to adapt as well as possible to these changes. (See Exhibit 4-5.)

Preventing the transmission of HIV must be a major focus of counseling interventions. Discussion of risk reduction should be incorporated as much as possible into all types of counseling. (See Risk Reduction Counseling, below.)

Discussion of risk reduction should be incorporated as much as possible into all types of counseling.

Individual Therapy

Individual therapy can be a particularly important component of treatment for a patient who may not be ready to share intimate information with a group. Individual counseling may allow patients to discuss subjects such as sexual behavior, fear of death, and other issues related to HIV infection, AOD abuse, or sexual identity.

For some AOD abusers, a possible disadvantage of individual therapy is that it may not be as potent as group intervention in reducing the sense of isolation, shame, and guilt that many

patients feel because of HIV infection. One aim of individual therapy may be to prepare patients to participate in group therapy.

Group Therapy

Most treatment programs working with HIV-infected AOD abuse patients are finding that supportive group therapy can be a highly beneficial modality.

AOD abuse treatment groups can be structured in a variety of ways but generally involve a dozen or so participants with one or two group leaders. HIV-infected AOD abusers who are strongly self-identified as heterosexual may not feel comfortable in a group with openly gay members, and vice versa. AOD abusers may be more reticent about exploring sexuality and sexual behavior in groups.

In general, however, it is not absolutely necessary to segregate group members on the basis of sexual orientation. Good results can be achieved in a group whose membership includes both HIV-infected and non-HIV-infected AOD abusers, as has been shown in the Stimulant Treatment Outpatient Program (STOP) at San Francisco General Hospital (Perez-Arce et al., 1993).

Stage-of-diagnosis model. A current model for structuring groups, based on the patients' stage of diagnosis, has been used successfully by Boston's Fenway Community Health Center. In this model, patients are grouped as follows:

- Those who have just learned about their HIV infection
- Those in the early stages of HIV disease.

These groups focus on healthy lifestyles and improving quality of life. As the sessions progress, patients often exchange information about treatment.

- Those in the later stages of HIV disease. This group focuses on adapting to illness, grief, and coming to terms with death and dying.

(See Support Groups, below, for further discussion of structuring groups.)

In addition to their therapeutic role, groups may have important roles to play in educating patients about HIV risk reduction. Discussions about risk reduction should be encouraged. Because it is important to promote behavior change among all AOD abuse patients, those who are not HIV infected should also have the opportunity to attend HIV education groups.

Family Therapy

For some HIV-infected AOD abuse patients, "family" may need to be defined as broadly as possible. Some patients will have traditional nuclear families. For other patients, family may include a nonmarital partner, a same-sex lover, and other significant others. Adult patients have the right to define their families and to decide whether or not to include the people they regard as family in the treatment process. For a socially isolated person, a buddy from an AIDS service organization may fill the role of significant other.

Supporting patients in their recovery from AOD abuse is often a principal goal of family therapy. Questions related to partner or child abuse may also be addressed. In addition, family therapy may be a useful opportunity to address issues of risk reduction for family members who are not (or not yet) HIV infected. This therapeutic setting is uniquely positioned to offer risk-reduction education to people who may not have been identified either as HIV-infected or as AOD abusers.

Effect of Cognitive Impairment

Both AOD abuse and HIV infection may cause cognitive impairment that can reduce adherence to medical care. The effect of cognitive impairment should be taken into account when undertaking patient education. It is important, for example, to allow time for recovery from the acute effects of AOD intoxication or withdrawal. Patients' ability to understand the content of counseling sessions should be assessed before such counseling takes place (Forstein, 1992). In general, it is preferable that counseling be offered in the later stages of a detoxification program.

Communication between medical and counseling staff is important to ensure that cognitively impaired patients are not perceived as deceitful or manipulative. Care providers must keep in mind that cognitively impaired patients' nonadherence to treatment is a result of the impairment

and not caused by denial, resistance, or unwillingness to accept care. (See Dementia in HIV Disease, above.)

Risk-Reduction Counseling

Changing risk behavior such as AOD use and unsafe sex requires more than a knowledge of why these are risk behaviors. Patients' attitudes and beliefs must also be addressed. AOD use can lower inhibitions and increase impulsivity, which may significantly contribute to risk behavior.

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In promoting risk reduction, the AOD abuse counselor's roles are to

- Help the patient understand the need for behavior change
- Provide psychological support for behavior change
- Assist the patient in developing the appropriate skills to sustain the behavior change.

Discussion of risk behaviors should take place in language that is both culturally appropriate and clear and understandable to the target audience. AOD programs should be familiar with how to refer family members for HIV antibody testing and with providing appropriate pre- and posttest counseling to patients. If onsite testing is not possible, referral should be available to an easily accessible site.

Risk-reduction counseling can be particularly difficult when a patient is sent back to a nonsupportive community where high-risk AOD and sexual behaviors are not discouraged. Issues such as poverty and homelessness must be acknowledged and addressed when attempting to change high-risk behavior. Practical assistance, such as providing emergency housing, is usually needed before behavior change can occur.

Sexual practices history. A comprehensive sexual practices history is important and should be taken early in counseling, although not necessarily at the first session. Patients must be reassured of the confidentiality of the information they provide.

Counselors should address the full range of potential risk behaviors in their questioning, including both needle sharing and unsafe sex. They need to take into account a wide range of sexual practices, including homosexual, bisexual, and heterosexual relations. Condom use must be a special focus of counseling.

A counselor can often proceed from taking the patient's history to HIV education and then to risk reduction. A patient who was diagnosed with HIV infection before the encounter with the counselor may already have discussed sensitive issues and risk reduction with someone. Therefore, it is important for the counselor to discuss with the patient what he or she has been told before.

Standardization of goals. Although counseling is necessarily an individualized process, some standardization of goals and methods can be helpful. Training, followup, and support for counselors is an integral part of the treatment program, especially for HIV-infected AOD-abusing patients with mental health problems. Counselors must be prepared to become familiar with all aspects of HIV disease. (See Counselor Training, below.)

Buddy system. The buddy system is an approach that has been tried in both HIV and AOD abuse treatment to increase patient compliance with treatment by increasing expectations about patients' responsibilities to one another.

The buddy system can place AOD abusers at risk if both buddies are in early recovery, in which case they may reinforce the possibility of relapse in each other. One strategy may be to pair a patient in early recovery with a buddy who has been in treatment longer. The appropriateness of the buddy system needs to be assessed individually in each patient.

Dealing With Ongoing AOD Abuse

Many HIV-infected AOD abusers are unable to maintain abrupt and total discontinuation of substance use. In dealing with patients' ongoing AOD use, treatment programs must find a balance between the **abstinence-oriented** and the **public-health-oriented** approaches to substance abuse treatment.

- **Abstinence model.** This approach traditionally uses confrontation, consistency of expectations, behavioral contracting, and limit setting as treatment modalities, with the goal of achieving abstinence from all substance use. This approach may involve termination from treatment if abstinence is not achieved.
- **Public health model.** This approach, sometimes called the *harm reduction* model, emphasizes incremental decreases in AOD use or HIV risk behaviors as treatment goals. This approach tends to try to keep patients in treatment even if complete abstinence is not achieved.

The public health model may sacrifice some of the consistency of expectations that is such an important part of abstinence-oriented treatment. Rather, it seeks to keep abusers in treatment and to reduce, if not eliminate, AOD- and HIV-related risk behaviors. Each incremental change may be viewed as a success, helping individuals to see that they can positively affect their lives.

By contrast, a model that regards anything less than complete abstinence as failure may reinforce individuals' sense of helplessness and hopelessness at their inability to sustain behavior change.

Flexibility is needed with HIV-infected patients because of the public health importance of keeping these patients in AOD treatment (they are likely to continue to put others at risk if they leave treatment and resume injection or other drug use). If reduction in the spread of HIV is an important goal, it may be necessary to keep working with these patients despite continuing abuse.

Flexibility is needed with HIV-infected patients because of the public health importance of keeping these patients in AOD treatment. If reduction in the spread of HIV is an important goal, it may be necessary to keep working with these patients despite continuing abuse.

Each AOD treatment program must establish its own balance between the abstinence and public health approaches, based on the needs of the community it serves. For example, harm reduction models may be employed to educate active IDUs about safer sex and drug use practices, such as using condoms and sterilizing needles with bleach. (See Appendix C.)

Differential standards of care. One current model for applying a flexible approach to the AOD abuse treatment of HIV-infected patients is the differential standards of care approach used by the Opiate Treatment Outpatient Program at San Francisco General Hospital's Substance Abuse Services. (See Appendix F.)

This approach applies different standards of care to patients, based on an assessment of the individual's level of functioning in the areas of physical health, mental health, social support, housing, and employment. Very ill patients generally are treated according to lower expectations of AOD abuse treatment outcome, while higher functioning patients are treated with higher expectations (for example, to maintain drug-negative urine tests, attend self-help group activities, etc.).

HIV Disease and Risk of Relapse

Declining health as a result of HIV disease is a recognized risk factor for relapse into AOD abuse. Physical and psychological stresses associated with HIV disease include pain, decreased functional ability, fatigue and weakness, as well as fear, anxiety, and grief, all of which increase individuals' risk of resuming substance use.

In particular, certain "milestones" in the progression of HIV present an elevated risk of patient relapse. Many patients may need additional support at these times. It is important that counselors review a patient's treatment plan when one of these milestones is reached and consider whether the patient would benefit from changes in treatment.

For most patients, four major milestones are

- Deciding to be tested for HIV infection and waiting for the test results. (Although making this decision can be a risk factor for relapse in some patients, for other individuals it may be a stimulus to begin AOD abuse treatment.)
- Obtaining the results of an HIV antibody test
- Developing the first symptoms of HIV disease
- Being diagnosed with AIDS.

AOD treatment counselors may wish to suggest the following strategies to patients who are at risk of relapse because of HIV-related stress:

- Individual counseling
- Participation in a peer support group
- Medical attention to relieve physical discomfort and alleviate anxiety
- Relaxation and stress management techniques
- Recreational activities.

Dealing With Patient Relapse

The most successful relapse counseling is nonjudgmental. However, patients should understand that preventing relapse is their responsibility. If a patient relapses into a risk behavior for AOD or HIV, the counselor's role is to help the patient to understand the conditions that caused the behavior to occur and to identify alternative behaviors that could have been substituted to prevent the relapse.

Relapse should be viewed as a learning experience and part of the recovery process. Patients should not be dismissed from AOD abuse treatment or HIV support groups because of a relapse. Rather, peer pressure may be constructively used to help patients acknowledge the reasons for and the consequences of their actions.

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Support Groups

Support groups fulfill a wide range of needs. In the AOD recovery process and in HIV treatment, they may be an important source of psychosocial support. They may also have an educational function, helping patients to gain knowledge and skills about the systems they must negotiate. Some support groups may have a patient advocacy role, helping to link programs and lobbying for funding to fill gaps in services.

No single organization can provide all the services needed by HIV-infected AOD abusers with mental health problems. AOD treatment programs should actively refer patients to appropriate outside support groups where their specialized needs can be met.

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Structuring Support Groups

Among the factors that must be considered in structuring support groups are the need to protect patient confidentiality and the possible stigmatizing effect of identifying a group as being for HIV-infected patients. (See accompanying box that provides an example of a support group.)

Among the issues that should be considered in establishing and maintaining support groups are language and ethnicity, gender, sexual orientation, type of AOD use, stage of recovery from AOD use, and stage of HIV infection. Trust tends to develop more quickly in homogenous groups than in groups with a heterogenous membership, although the latter can also work very well.

Language. The language or language style of the therapist or support group leader sets a tone for the group and influences how successfully group members interact. Group leaders must be fluent in the language or vernacular spoken by patients.

Gender. Single-sex groups may be beneficial for both women and men in certain circumstances. Women who have suffered abuse may feel more able to divulge this information in a women-only group.

Many HIV-positive women may not have told their partners about their status and some may be afraid of losing custody of their children if their status becomes known. Women who have been involved in the sex industry or in sex-for-drugs transactions may have difficulty speaking about these experiences in mixed settings and may benefit from participation in specialized single-sex groups.

Single-sex groups may also be beneficial for men who have difficulty discussing issues of sexuality, such as sexual abuse and incest, in a mixed-gender group.

Sexual orientation. Some patients may have difficulty achieving full recovery from AOD abuse without addressing issues related to sexual orientation. Homosexual and heterosexual IDUs may not always be comfortable with one another in groups. Ideally, if resources allow, specialized groups should be offered that are defined by both sexual orientation and gender.

Type of AOD use. Patients' perceptions and prejudices about the use of different substances are likely to surface in groups and affect the treatment process. For example, alcohol abusers may consider themselves less addicted than IDUs and may be unwilling to admit that they also use illicit drugs. In general, it is preferable to have separate groups for alcohol abusers, heroin abusers, cocaine abusers, and so on.

Stage of recovery from AOD use. An individual's stage of recovery may be as important as the type of substance abused. Although most AOD abuse treatment programs stress abstinence, patients in early recovery who are also dealing with HIV infection may find total abstinence difficult to achieve.

Stage of HIV infection. Segregating groups by stage of HIV infection presents difficulties, but not doing so can also be problematic. Patients who are HIV-positive but asymptomatic and attending a support group for the first time may be uncomfortable at encountering patients in

the late stages of AIDS. Such a meeting may force them to confront fears about their own mortality before they are ready to do so.

Because treatment programs have limited resources, separating groups by stage of HIV infection may be impractical. Programs able to support separate groups (See Group Therapy, above) may wish to use the three-group model with groups of

- Patients newly aware of their positive HIV status
- Those who are asymptomatic or mildly symptomatic
- Those with more advanced disease.

Issues To Be Considered in EstablishingAnd Maintaining Support Groups

- Language
- Gender
- Sexual orientation
- Type of AOD use
- Stage of recovery from AOD use
- Stage of HIV infection.

The interplay between AOD abuse and HIV infection in groups can be complicated. As patients move further into AOD recovery, they may be getting progressively more ill from HIV disease. In a mixed group, healthier patients may provide support to sicker ones.

In a group consisting solely of patients with advanced HIV disease, members are vulnerable to becoming involved in a process of continual grieving. Sometimes groups have to discontinue for a period of time when too many members become sick or die. For this reason, it may be helpful to establish support groups for time-limited periods. (See Grief and Bereavement, below.)

Alternative Therapies

Peer programs can provide support for AOD recovery and other psychosocial services. There are many resources in the community for these interventions; all that a program has to provide is a meeting place. It is helpful if the peer group facilitator has some training, even if this consists solely of the orientation that all AOD program volunteers receive. Potential problems with peer programs are confidentiality and liability. Because they are not led by professionals, peer groups may be limited in what they can achieve. However, the absence of professional involvement may give peer groups greater credibility with hard-to-reach patients.

Role playing is an effective health education technique that can be used to build patients' skills at negotiating for the use of a condom during sex, telling a partner or family members that one is HIV-infected, turning down an offer of drugs, or dealing with a public official.

Acupuncture. There is some evidence that acupuncture may be a beneficial adjunct to treatment for many forms of AOD abuse. It may, for example, help some patients to continue in treatment longer than they otherwise might.

Meditation is another supplement to traditional treatment that some patients may find helpful.

Grief and Bereavement

In addition to facing the prospect of disability and death from AIDS, many HIV-infected AOD abusers experience grief and bereavement as a result of the deaths of friends, lovers, spouses, and other family members. For AOD programs, dealing with patients' grief and bereavement presents three sets of issues:

- Providing support and counseling for patients who
- are dying as well as for patients who are experiencing the deaths of significant others
- Supporting staff who are experiencing grief and stress as a result of working with dying patients
- Establishing flexible program policies that accommodate the limitations of symptomatic HIV-infected patients.

Supportive Services for Ill, Dying, and Bereaved Patients

Patients facing progressive illness and disability need a variety of supportive services:

- Support groups and supportive individual counseling
- Education about healthcare and the expected course of illness (to reduce uncertainty, anxiety, and fear)
- Support in dealing with denial, especially if it interferes with receiving medical care.

Counseling of ill and dying patients should be supportive and nonconfrontational, addressing issues relevant to the patient's illness at a pace determined by the patient. Patients who are in denial about their illness will delay making arrangements for medical and nursing care and procuring assistance with activities of daily living. Counseling can play an important role in helping patients to accept the eventual need for home health or hospice care.

Bereavement is a particular problem for programs with large numbers of HIV-infected patients. The following are some strategies that may be helpful in supporting patients who are dealing with bereavement:

- Acknowledging the reality of bereavement in supportive individual counseling
- Encouraging the expression of grief both verbally and nonverbally (for example, through art therapy and other similar interventions)
- Providing group support for clients who are experiencing grief and bereavement
- Acknowledging patients' deaths with memorial services, flowers, photographs, and participation in commemorative projects such as the NAMES quilt.

Avoiding Staff Burnout

Staff working with HIV-infected AOD abuse patients may experience high levels of stress. Not only are counselors and other staff members continually confronting the illness and death of their patients, but AOD treatment personnel themselves—many of whom are themselves recovering AOD abusers -- may also be infected with HIV and facing the same health problems as their patients.

To address these problems, staff should be rotated periodically, although not so frequently that there is no consistency for patients. Attendance at a staff support group should be mandatory; whatever the scheduling difficulties, this group should meet at least monthly. Staff members who are themselves recovering AOD abusers need to acknowledge their own potential for relapse because of the stress of their work.

Staff working with HIV-infected AOD abuse patients may experience high levels of stress. Attendance at a staff support group should be mandatory; whatever the scheduling difficulties, this group should meet at least monthly.

Inservice training programs on stress management and issues related to death and dying can also be helpful to staff working with HIV-infected AOD abuse patients.

Program Flexibility

Programs may need to adjust their expectations of treatment outcome to accommodate patients who are facing progressive disability from HIV disease. Standards established for the treatment of relatively healthy AOD abusers may not be appropriate for symptomatic HIV-infected individuals.

Opioid substitution therapy programs. Patients maintained on methadone are normally expected to attend the methadone clinic every day to receive their medication. But as HIV-infected patients develop symptoms such as fatigue, shortness of breath, and nerve and muscle damage, daily clinic attendance will become more difficult and may eventually become impossible. Flexible policies regarding "take home" methadone doses are required to meet the needs of these patients.

Residential treatment programs. Patients with symptomatic HIV disease may be physically unable to perform all the tasks normally expected of members of a residential treatment program. Programs should have the flexibility to accommodate these patients' limitations by offering them lighter duties.

In addition, the length of residential treatment programs may be unrealistic for symptomatic HIV-infected patients. Walden House, a residential AOD treatment program in San Francisco, offers a 6- to 12-month program for patients with HIV disease. Shorter treatment programs may be necessary to meet the needs of individuals with HIV disease whose life expectancy may be limited but who nevertheless can benefit from AOD treatment.

Counselor Training

HIV education. At this stage in the HIV epidemic, given the close links that exist between HIV and AOD, all those working in the AOD treatment field should be knowledgeable about HIV disease. In particular, AOD abuse counselors should understand HIV transmission routes, risk assessment and reduction techniques, and basic medical information about HIV/AIDS.

Sexuality. Good clinical supervision can help counselors overcome their difficulty in discussing sensitive issues such as sexuality. With training, AOD counselors can learn techniques for helping clients to talk about the intimate details of their sexual behavior. They can also learn how to use a candle, banana, or some other prop to demonstrate the proper use of a condom.

Education about mental illness. Counselors should receive training that addresses fundamental mental illness issues. Cross-training that addresses mental illness in relation to HIV disease is also important.

Risk reduction. Programs may find that discussions of risk reduction can best be handled by a staff member who specializes in HIV education. Educational material for patients about HIV is available from most State health department libraries. For information about training programs in HIV education for AOD abuse treatment providers, contact the appropriate State health department.

In this rapidly changing field, counselors must be ready to be honest about not knowing the answer to every question. Because of the large volume of new information that is continually being generated about both HIV infection and AOD abuse, regular educational updates for staff are essential. Educational sessions should be held at least once a month.

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TIP 15: Chapter 5—Social Services for HIV-Infected AOD Abusers

Meeting the social service needs of alcohol and other drug (AOD) abusers who become infected with HIV is an enormous challenge. A population that already has complex social service needs because of AOD abuse now has additional needs as a result of HIV infection. Further, this population may not be accustomed to going outside of the AOD abuse provider community to obtain services.

The nature of HIV disease requires an individual to actively utilize many social services, including housing; home healthcare; entitlement programs for medical care, food, transportation, and childcare services; respite care and support for caregivers and families; and legal and advocacy services.

Meeting these needs in an appropriate, comprehensive, and coordinated manner is a challenge because HIV-related disease is a complex condition and the social service system is decentralized. Typically, agencies at different levels of government are charged with providing different services such as housing, child welfare services, or entitlements. As a result, providers often must work with many agencies, secure different types of documentation from clients, and make sure clients follow through with procedures to become eligible for or receive services. The

process can be confusing, labor intensive, and frustrating. Regulations, procedures, and eligibility requirements sometimes differ within and among agencies, further complicating efforts to secure needed social services for clients.

Providing social services to HIV-infected AOD abusers requires a high degree of cooperation and coordination among agencies. By working together, agencies can utilize existing services more effectively and break down barriers preventing service delivery. Different provider agencies serving HIV-infected AOD abusers must become familiar with various services, procedures, and eligibility requirements; develop good working relationships; devise ways to use existing community resources; and develop new mechanisms and resources to better meet the social service needs of this population.

Providing social services to HIV-infected AOD abusers requires a high degree of cooperation and coordination among agencies. By working together, agencies can utilize existing services more effectively and break down barriers preventing service delivery.

In addition, staff from each provider agency should receive training in cultural sensitivity and competence so that they can provide effective services to this diverse population. Different cultures respond in a variety of ways to drug use, homosexuality, and illnesses such as HIV disease, and staff should understand these issues and their effects on clients' beliefs and behaviors. Moreover, staff members should understand that they themselves have likely internalized many beliefs and values of their own culture that must be examined. (See accompanying box on Cultural Sensitivity and Competence.)

AOD programs providing services to HIV-infected AOD abusers should have a thorough knowledge of the broad range of needs of this population. They should keep in mind, for example, that after years of chronic substance use and distressing behavior many substance abusers have alienated their family members and severed ties with friends who might provide support. This isolation can affect the individual's emotional and physical health and create an obstacle to even the most integrated delivery of social services. Persons with HIV disease have a variety of special needs. Many persons with AIDS need daily intravenous infusions of

medications, either self-administered or provided by a caregiver or home health aid. Many need appetizing meals or transportation to grocery stores and physicians' offices. Some need periodic care for their children or help with housework. Some individuals lose their sight and need assistance in daily activities. Some may need help caring for pets -- for example, walking dogs. Others may need assistance with legal problems with employers or landlords or with making a will or arranging for guardianship of their children. It is only when providers understand the many needs of this population that they can take constructive and creative steps toward meeting them.

Cultural Sensitivity and Competence The following are steps that treatment programs can take to enhance their cultural sensitivity and competence:

- Establishing liaisons with culturally specific community groups and services.
- Making active efforts to hire staff who are diverse in ethnicity, sexual orientation, and cultural identification. A commitment to the recruitment of a diverse staff involves advertising vacancies in specialist publications and accepting that additional time may be needed to fill vacancies.
- Training treatment staff about the lifestyles, value systems, and communication styles of ethnic, homosexual, and bisexual populations through inservice training, literature, and offsite workshops (Cabaj, 1989; Marin, 1989). Treatment staff may rotate through community clinics that serve specific populations to become more knowledgeable about education, prevention, and treatment in a culturally aware context.
- Displaying nonjudgmental, culture-affirming attitudes. Asking questions that relate to the client's sexual orientation and link to his or her community affiliations (for example, through the church, through various cultural ceremonies, or through the acceptance of non-Western healing practices such as acupuncture, *curanderismo*, sweat lodges, and *santerRa*) provides a sense that members of ethnic and cultural communities and

their practices are accepted. (Appendix D includes a questionnaire from the San Francisco AIDS Foundation to assess the level of an agency's cultural proficiency.)

In this chapter, the social service needs of HIV-infected AOD abusers in four areas are described. In the following chapter, strategies for integrating services to meet these needs are described.

The four areas discussed in this chapter are:

- Housing (including supported housing programs, home healthcare, homeless shelters, and hospice care)
- Family support
- Case management
- Outreach.

Housing

An individual's untreated AOD abuse may in itself lead to homelessness, a condition that becomes doubly critical when the individual is also HIV infected. Appropriate and affordable housing is often not available for those living with HIV. It is not uncommon for them to encounter substantial barriers that make it difficult to obtain adequate housing. These barriers may include discrimination, lack of financial resources or health insurance, and the need for support and assistance with activities of daily living.

Appropriate and affordable housing is often not available for those living with HIV. It is not uncommon for them to encounter substantial barriers that make it difficult to obtain adequate housing.

Need for a Continuum of Care

Ideally, housing services should address both HIV disease and AOD addiction through the provision of comprehensive in-home services or through collaboration with other providers.

Housing should be available for all HIV-infected AOD abusers, from asymptomatic to terminally ill persons, and from active AOD abusers to those in long-term recovery. Residential programs should provide a continuum of care because clients' needs vary at different stages in AOD or HIV treatment. It is unrealistic to expect programs to provide all the services that clients may need at different times. However, programs should establish referral mechanisms and internal policies and procedures that enable them to provide a continuum of care to AOD abuse clients who are living with HIV/AIDS.

In addition to referral mechanisms, collaborative relationships need to be established with outside agencies for additional resources and technical assistance. Residential programs and facilities also should provide training for staff in the complex needs of this population, both in terms of their AOD abuse and their HIV disease.

Residential programs should be aware that one of the priorities of the Ryan White CARE Act is to provide a comprehensive continuum of care to individuals with HIV disease and their families. Programs may wish to explore obtaining CARE Act funds to create home health services and hospice services for HIV-infected AOD abuse clients. (See summary of CARE Act in Appendix E.)

Several residential programs have been developed by therapeutic communities (TCs) to respond to treatment needs of persons with HIV/AIDS, and others may wish to model their services on these programs. Prototypes, a TC for women and children in the Los Angeles area, has revised some of its rules and procedures to provide a continuum of care and meet the special medical and other needs of HIV-infected women (see box on next page on custody). RAP, Inc., an Afrocentric TC in Washington, D.C., has established a special HIV/AIDS residence that includes people at different stages of AOD recovery and has adjusted rules and procedures to provide a continuum of care that meets the needs of HIV-infected residents.

Housing Access and Availability

Access to and availability of housing are two key issues for HIV-infected AOD abusers. Currently, in many communities, the demand for housing and residential treatment programs for HIV-infected AOD abusers far exceeds the availability of programs or slots.

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In addition, existing HIV/AIDS residential programs often have regulations or requirements that make HIV-infected AOD abusers ineligible for their services. For example, programs may require that residents be free of AOD use for 6 to 12 months, have no convictions for sales of drugs or sex, have no mental health disorders, and do not receive methadone maintenance treatment. The latter requirement is usually related to the HIV/AIDS residential program staff's lack of familiarity with methadone maintenance.

Two models of independent-living residential programs for HIV-infected AOD abusers are "sober hotels" and Oxford Houses. Sober hotels were developed in San Francisco to provide single rooms in a downtown location for homeless men, many of whom are HIV infected and who are not currently abusing AODs. Oxford Houses are group residences for people in recovery from AOD abuse, managed by the residents with the assistance of professional staff. The first Oxford House was established in the Washington, D.C., metropolitan area in 1975, and there are now hundreds of similar recovery houses throughout the United States. Under Public Law 100-690 (the Anti-Drug Abuse Act of 1988), each State is required to establish a revolving fund to make loans to cover the first month's rent and security deposit for housing for groups of recovering individuals. Each new Oxford House group is given an Oxford House charter and receives assistance from a national office in operating a successful recovery house.

Active AOD abusers are the most difficult clients to house. A balance must be struck between empathy and harm reduction on one side and collusion and enabling on the other. Housing a known AOD user can be problematic for a residential program. It can create discipline and safety problems, as well as discomfort for the other residents. Some HIV/AIDS residences admit AOD users, with no particular requirements affecting them. Others may impose requirements. If a

program does not impose sanctions for active AOD use, it may be aiding in the client's addiction and may jeopardize others' progress in recovery. On the other hand, requiring abstinence and/or participation in treatment (such as methadone maintenance or counseling) can present problems if an individual is too ill to comply; such requirements may jeopardize the individual's participation in a residential program.

Providers of residential services need education about opioid substitution therapy. Such education would help end the discrimination against methadone-maintained clients that still exists in some areas and would increase their access to residential and housing programs. Residential service providers should familiarize themselves with methadone maintenance treatment programs (MMTPs) and establish collaborative relationships with them to enable residents to remain in methadone maintenance treatment while they are in residence. Likewise, MMTPs should network with residential programs, educate them about their clients' needs, and establish collaborative relationships with staff of residential programs to increase their clients' access to these services. Three other Treatment Improvement Protocols (TIPs) in this series contain detailed information about providing opioid substitution therapy services -- methadone and LAAM -- and an array of adjunct services. These TIPs include *State Methadone Treatment Guidelines, Matching Treatment to Patient Needs in Opioid Substitution Therapy, and LAAM in the Treatment of Opiate Addiction.*

Custody of Children of HIV-Infected Parents Guardianship or custody of children in the event of serious illness or death of a parent who has AIDS may be determined in a number of ways, including:

- Adoption while the parent is alive. This provides certainty in determining who the children's legal guardian will be.
- Legal custody that allows another adult to make decisions concerning the child. Custody arrangements vary from State to State.
- Appointment of a permanent guardian in a parent's will.

Some States permit "springing guardianship" or "standby guardianship," a flexible arrangement that enables a seriously ill parent to remain involved in children's upbringing while competent but

provides for temporary guardianship during periods when the parent becomes incompetent. Legal advice should be sought, preferably from an attorney who is experienced in both HIV and child welfare issues, before a client makes important decisions about the future of a child or children.

HIV-Infected Children

- AOD program staff should be educated about the foster care and adoption systems in their States and in particular about specific regulations that may exist concerning HIV-infected children. Special training should be provided to staff of AOD abuse programs on issues regarding AOD/HIV and children. The names of national and State organizations with expertise in this area can be obtained by contacting State HIV/AIDS agencies.

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Support for Prospective Foster and Adoptive Parents of HIV-Infected Children

- Prospective caretakers must clearly understand the legal and financial ramifications of being a foster or adoptive parent of an HIV-infected child. Providing emotional support and social services to foster or adoptive parents will help them in caring for the children of dying or deceased clients. Programs should ensure that prospective foster or adoptive parents receive competent advice and accurate information. If program staff do not have the necessary expertise, the prospective parents should be referred to child welfare agencies or to attorneys knowledgeable about legal issues relating to both HIV and child welfare. Programs should

contact the social service/child welfare agencies in their States for information about the support services and benefits available to natural, foster, or adoptive parents of an HIV-infected child. Typically, the State social service/child welfare agency pays a monthly stipend to foster and adoptive parents for the care of the child. State child welfare agencies provide supplemental stipends to children designated to have special needs, and HIV-infected children sometimes receive this designation. Foster children are automatically eligible for Medicaid. Also, children are eligible for Medicaid once they are legally adopted.

Community education is also needed to facilitate placing residential programs in neighborhoods conducive to the maintenance of a healthy lifestyle. At present, supported housing services are often located in areas with high rates of AOD use, challenging residents' continued abstinence. The Federal Fair Housing Assistance Act, the Federal Americans With Disabilities Act, and the Public Health Service Act authorizing the provision of substance abuse prevention and treatment block grants have removed substantial barriers to the establishment of special housing programs. However, community education by AOD treatment programs, residential programs, and advocacy groups is still essential to overcome the "not in my backyard" (NIMBY) syndrome.

Active AOD abusers are the most difficult clients to house. A balance must be struck between empathy and harm reduction on one side and collusion and enabling on the other.

Residential AOD treatment programs that are publicly funded or licensed should be aware that they are required to comply with the provisions of the 1990 Americans With Disabilities Act regarding housing accessibility for individuals with physical disabilities (National Council on Disability, 1993.) Appropriate modifications might include, for example, adding ramps and wheelchair-accessible toilet and bathing facilities. (See Access to Treatment section in Chapter 7.)

Symptomatic HIV-infected persons often require services in addition to those offered in traditional residential housing programs. Helpful efforts might include referrals to appropriate

resources or incorporation of new services into existing residential programs. For example, residential programs can help residents arrange for take-home methadone or provide transportation to AOD treatment programs, medical appointments, and support group meetings.

Home Healthcare

Comprehensive and coordinated home healthcare services for HIV-infected AOD patients should include the following elements:

- Coordination with public health nurses, home health aides, AOD counselors, and other individuals working with patients
- Case conferences with the patient, family, and other health workers involved in the patient's care
- Family counseling and education
- A team approach: representatives from all institutions and disciplines should be involved in planning and monitoring home-based care.

Although home healthcare is an important part of the continuum of housing support services, it is often fragmented, with a confusing array of services, funding sources, and restrictions. Resources are often insufficient to meet needs. Coordination and collaboration among housing programs, social service agencies, and home healthcare agencies are essential to ensure the effective delivery of these services to HIV-infected AOD abusers.

For patients on opioid substitution therapy, home healthcare presents special problems. Home healthcare workers are typically not authorized to dispense medications. As a result, many individuals receiving methadone maintenance treatment must be hospitalized in order to be kept on their treatment regimen. However, the Food and Drug Administration grants waivers on an individual basis so that clients who are too sick to pick up their methadone can arrange for it to be picked up for them -- by home health workers or residential staff, for example.

Home healthcare workers are typically not authorized to dispense medications. As a result, many individuals receiving methadone maintenance treatment must be hospitalized in order to be kept on their treatment regimen.

Home healthcare workers could benefit from training in AOD abuse and HIV issues. Certified and/or approved training courses offered by agencies such as the American Red Cross may be utilized, or home health agencies may wish to develop inhouse staff training programs. In addition, home health staff should receive cultural sensitivity training to increase their level of comfort in dealing with people of different ethnicities, economic backgrounds, and sexual orientations.

Hospice Care

A hospice program provides palliative care (care that enhances comfort and strives to improve quality of life) to individuals who are terminally ill. Hospices also provide around-the-clock supportive services to patients and their families or significant others.

Hospices originated in England as residential facilities; however, in the United States, 90 percent of hospice care is provided in the home. Hospice care typically involves a primary caregiver—usually a partner or family member living at the same residence -- who is willing and able to provide ongoing care to the patient. Most hospices provide volunteers to help the primary caregiver.

Some hospices are inpatient facilities, either freestanding independent facilities or based in hospitals or nursing homes. Depending on their needs, patients may receive hospice care both in a hospital and at home during the end stage of their illness. Although most hospice care requires that the patient have a place to live, some hospices will provide care in residential facilities other than in a private home. Some hospices also provide a residence for homeless people.

Traditionally, hospice care was designed to deliver care in the end stage of a terminal illness. However, in response to the AIDS crisis, many hospices now accept AIDS patients at earlier stages of disease and are more flexible about accepting AIDS patients who are receiving medical

treatment for opportunistic infections. Hospices do not accept patients who are receiving medical treatment to prolong life; however, they will accept patients who are receiving treatment to make them more comfortable. Hospice care would not be appropriate for asymptomatic or mildly symptomatic HIV patients.

Most hospices are Medicare certified and in some States they can accept Medicaid. In addition, many private insurers provide coverage for hospice care.

Homeless Shelters

According to the report of the National Commission on AIDS Working Group on Social/Human Issues, "Affordable and appropriate housing is of critical importance to persons with HIV disease, yet an estimated 20,000 to 32,000 HIV-infected individuals are homeless. Many others are in immediate danger of becoming homeless" (National Commission on AIDS, 1991). Tuberculosis (TB) is a serious problem in many homeless shelters, and a significant percentage of people living in shelters are HIV-infected AOD abusers.

Despite the high incidence of AOD abuse among homeless people, homeless shelters are often not considered part of the AOD treatment system and are excluded from the service planning and delivery process. Medical care and AOD services provided in shelters are often inadequate. Many shelters require residents to leave the facility early in the morning and return in the evening; such policies are particularly problematic for residents who are ill, including those with HIV disease or TB. Shelter residents and staff may lack knowledge about the relationships between AOD use and infectious diseases, including HIV and TB. AOD treatment providers should make efforts to develop linkages with homeless shelters in order to overcome these barriers and provide services to this hard-to-reach population.

Tuberculosis is a serious problem in many homeless shelters, and a significant percentage of people living in shelters are HIV-infected AOD abusers.

Family Support

It is helpful to define "family" broadly to encompass both traditional and nontraditional families. Family may include significant others—individuals who may be unrelated but who have a close relationship with the client and provide for the client's physical, emotional, and spiritual well-being. Family members and significant others should be encouraged to participate actively in treatment planning and medical care decisions regarding the client's AOD problems and HIV disease.

All family members who provide close support to the seriously ill member often need support themselves. Providing social service support for the family is a cornerstone in the provision of coordinated, comprehensive care to HIV-infected AOD abusers. For example, the provision of home-based services may be critical in enabling a family to remain together, and it may also be more cost-effective than institutionalization of the HIV-infected family member.

All family members who provide close support to the seriously ill member often need support themselves. Providing social service support for the family is a cornerstone in the provision of coordinated, comprehensive care to HIV-infected AOD abusers.

Case Management

Case management is the process of linking patients with needed services, particularly when these services are located at different sites and provided by different agencies. Case management originated in the social work profession and has become a standard practice in the social services and mental health fields.

While there is no single, universally accepted definition of case management, the term can be broadly defined as *a process in which the full range of services is identified to meet a person's psychosocial, economic, and health-related needs either directly or through linkage and referral*. The case manager is the professional responsible for coordinating the patient's care and arranging access to needed services, often also serving as an advocate and broker. In the AOD treatment field, case management can involve arranging access to needed services that are not part of a client's formal treatment program such as aftercare, followup, family support, and

referrals to other agencies. Four models of case management are described in the accompanying box, entitled "Role of the Case Manager: Four Models," including one developed by the consensus panel.

An important function of the case manager is to ensure that HIV-infected AOD abusers gain access to entitlement benefits, such as food stamps, Medicare and Medicaid, and supplementary income. Applying for eligibility for various programs and maintaining eligibility status often require special knowledge of program regulations and may involve completing forms and contacting a variety of agency personnel -- procedures that may be daunting or confusing, especially to a person who is ill. Case managers should develop a working knowledge of entitlement programs that may benefit HIV-infected AOD abusers. (See box on Entitlements and the Representative Payee Program.)

It is important to note that case management with any population involves a high level of skill and knowledge. Traditionally, AOD treatment providers have not hired enough professional social workers to carry out these responsibilities for substance abuse clients. In addition, they often do not provide adequate training to personnel, such as AOD counselors, who are assigned these duties. Case management with HIV-infected AOD abusers is labor intensive and requires specialized knowledge and skills. AOD providers will have to revise their expectations regarding caseload size and frequency and length of client contact when case managers are assigned to work with these clients.

Services for HIV-infected AOD abusers are typically provided by a variety of treatment agencies, each of which has different funding sources, regulations, and responsibilities for specific aspects of care. Case management plays a critical role in promoting a continuum of care by ensuring that clients are linked to needed services and are receiving appropriate therapy that does not conflict with their AOD treatment.

A variety of models of case management for HIV-infected individuals have evolved as a result of different funding sources and methods of healthcare financing. The report of the National

Commission on AIDS Working Group on Social/Human Issues (1991) described the various models of case management as follows.

In some instances, case management is funded by the government, is hospital-based, and is primarily linked to discharge planning. Other case management programs, particularly those funded by the Health Resources and Services Administration (HRSA) and the Robert Wood Johnson Foundation (RWJ), are more community based and follow individuals both in the hospital and beyond. In some States, case management is provided by Medicaid programs, especially in States with home- and community-based waiver programs. Yet other programs have emanated from prepaid, managed care programs in health maintenance organizations (HMOs).

Effective case management for HIV-infected AOD abusers encompasses linkages with a full spectrum of services and agencies, including:

- AOD treatment programs
- Mental health services
- Child welfare agencies, including foster care and protective services
- Community resources, including AIDS service organizations, and churches
- Legal services
- Public entitlement programs
- Perinatal addiction programs
- Educational programs, including ones for children who are exposed to drugs in the community
- HIV-specific health and counseling services
- Programs that provide basic services, such as food, housing, transportation, respite care, and childcare.

Case management requires linkages among agencies responsible for different aspects of a client's care. It is recommended that formal interagency agreements be established that clarify the responsibilities of all the organizations providing services to clients. (See discussion of interagency agreements in Chapter 7.) Agencies should also have agreed-upon procedures for

interagency communication and evaluation mechanisms to track the effectiveness and outcomes of case management on an individual's or family's health status. It may also be helpful to calculate the levels and types of staff, resources, and facilities needed to carry out effective case management, bearing in mind that clients' needs for intensive case management services will vary depending on their stage of AOD and HIV treatment.

Role of the Case Manager: Four Models Three models of case management have been described, differentiated by the case manager's level of involvement in managing the care of an individual patient. In each model, the case manager may be affiliated with one of several disciplines, such as social work, nursing, or substance abuse treatment. Because AOD abusers may not be accustomed to going outside of the AOD treatment provider community to obtain services, effective case management can often best be accomplished by an AOD counselor or other personnel in the treatment field. A fourth model, in which the case manager is the primary therapist, was added by the CSAT consensus panel social services workgroup.

- Comprehensive Case Manager Model. In this model, the case manager's responsibilities include service coordination; advocacy; and assistance in dealing with health, social services, and substance abuse treatment agencies. The case manager can be based within an AOD treatment program, a primary healthcare clinic, or a community-based social service organization.
- Case Coordinator Model. The case coordinator is responsible for conducting followup with the designated contact person at each agency providing services to the client to ensure that appointments are being kept and needs identified. The case coordinator may receive copies of a checklist from each provider. The case coordinator can be based within an AOD treatment program, a primary healthcare clinic, or a community-based social service organization.
- Hospital-Based Caseworker Model. This model differs from the others in that the caseworker is hospital based. The caseworker is responsible for

coordinating referrals for hospitalized patients who are identified as being HIV-infected AOD abusers. Referrals are made to AOD treatment providers, outpatient medical services (for HIV treatment), and social service agencies, as well as to hospital- and community-based recovery support groups, such as 12-step programs. The caseworker is usually employed by the hospital, although funding for the position might come from a foundation or from a local Ryan White CARE consortium.

- Case Manager as Primary Therapist. This model is common in AOD abuse treatment programs, in which the client's primary therapist functions as case manager. In some cases, the AOD abuse counselor can be a very effective case manager for the HIV-infected client.

Outreach Services

Staff members of many social service agencies and community-based organizations perform outreach functions to deliver specific services to populations that may not otherwise seek or have access to services. AOD outreach workers play a key role in encouraging AOD abusers to seek and remain in treatment, comply with medication regimens, and reduce HIV risk behaviors such as unsafe drug-taking practices, unsafe sexual practices, and AOD abuse. Street outreach workers perform an essential public health role; they gather information critical to the development of effective public health policy and are on the front lines in terms of implementing health policy. Screening for infectious diseases such as HIV-disease, TB, and sexually transmitted diseases is an important function of outreach workers. Another TIP in this series, *Simple Screening for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases,* provides an overview of this important aspect of the role of outreach workers.

Street outreach workers perform an essential public health role; they gather information critical to the development of effective public health policy and are on the front lines in terms of implementing health policy.

Case finding, counseling, and creating linkages with other health and social services agencies are other important responsibilities of outreach workers. Like case managers, outreach workers may have a coordinating role among social service agencies, healthcare providers, community organizations, and AOD treatment facilities to ensure that clients obtain needed services. AOD programs providing services to HIV-infected AOD abusers should recognize the vital role played by outreach workers in serving many individuals in this population and should include outreach workers in staff planning meetings and case conferences and as active members of the program's interdisciplinary team.

For example, outreach worker participation in discharge planning can facilitate continuity of care for patients. An outreach worker who is in close contact with a client may be in the best position to determine whether a discharge plan realistically meets the individual's needs. In addition, when the outreach worker is involved in the discharge planning process, he or she can more easily track the patient after discharge.

Outreach workers may also provide:

- Crisis counseling and referrals for emergency care to AOD abusers not enrolled in treatment
- Assistance in securing transportation, childcare, and other services that may encourage AOD abusers to enter or reenter treatment
- Monitoring AOD abusers' consumption of medications through home or street visits
- Consultation and education to other social service agencies, healthcare providers, and community- based organizations on AOD abuse and HIV issues.

AOD outreach workers should be familiar with the community in which they work. For example, outreach workers performing HIV risk reduction education among heroin addicts must know where these individuals congregate (for example, in shooting galleries or abandoned buildings) and be comfortable working in these settings. Similarly, they can benefit from knowing about

national organizations and hotlines. Both can be the source of helpful information and materials for use in community work.

Many AOD outreach workers are themselves in recovery from AOD abuse. Although support groups for all outreach workers are very important, workers who are in recovery have special needs that should be addressed in support groups. These individuals must be secure enough in their recovery process to resist relapse when their work brings them into close contact with persons who are currently abusing AODs.

Prototypes, a therapeutic community in the Los Angeles area and described in the box on the next page, is a program that successfully employs individuals in recovery to conduct outreach. This program hired and trained 25 local women, many of whom had been sex workers or partners of sex workers. Following their training, the women returned to their communities to educate other female AOD abusers about high-risk behaviors and encourage them to enter treatment.

Entitlements and the Representative Payee Program

- An understanding by case managers of the often confusing process of applying for public assistance -- including Medicaid, Supplemental Security Income (SSI), and food stamps -- will help ensure that clients receive benefits for which they are eligible. AIDS service organizations that have developed expertise in this area can be consulted for technical assistance. Case managers also need to be familiar with the problem of long waiting periods to receive SSI benefits and with the SSI representative payee program.
- HIV-infected individuals can qualify for SSI benefits if they are considered to be permanently disabled by HIV disease. Because there is usually a long wait from the time of application for benefits to receipt of the first payment, clients often receive large back payments. To safeguard against the risk that AOD-abusing clients will spend the lump sum or monthly SSI

benefit to support their addiction, a "representative payee" arrangement may be established in which the benefit is paid to an individual who acts as the client's representative. The case manager can work with the client to identify a family member or significant other who is willing to be the representative payee. Strict laws and regulations are in effect to prevent misuse of SSI funds by representative payees.

Prototypes: A Program That Keeps Families Together

- Prototypes is a therapeutic community (TC) in Los Angeles that provides services to families. It offers comprehensive residential, day treatment, and outpatient AOD services for women and their children. A culturally competent staff provides case management and conducts extensive outreach to women who are not in AOD abuse treatment and are living in homeless shelters, battered women's shelters, or on the street. Program compliance requirements are flexible and are adapted to the needs of HIV-infected women, with the goal of keeping them in the program as long as possible.
- Support services are offered for pregnant women who are AOD abusers and/or HIV infected. When an HIV-infected woman has to be hospitalized, her treatment slot is kept open for her and the program continues to provide support for her children. Women on methadone are accepted into the program. Lesbian women are welcomed, and psychological support is provided for their partners.
- Vocational rehabilitation and job training are provided for clients, and special programs are offered for women who are HIV infected and need to work part time. For example, word processing skills are encouraged because there are many part-time employment opportunities in this area. Self-sufficiency is emphasized, with at least three choices of different

kinds of work training opportunities offered within the job training and education program.

- The health department actively supports screening of Prototypes clients for TB and other infectious diseases. The program has established linkages with child welfare, social services, and criminal justice agencies; entitlement programs; and the school system. In addition, the program has developed diversion programs with the criminal justice system to keep women out of prison and decrease the need for women to be separated from their children.
- Prototypes offers more than 25 different core group counseling sessions dealing with a broad range of AOD and self-sufficiency issues. Pastoral care and spiritual support are also available. The program helps HIV-infected women plan for the care of their children after their death by assisting with writing wills and designating guardians, foster parents, or personal representatives for the children.

TIP 15: Chapter 6—Linkages and Services Integration: Policy and Implementation

Persons with human immunodeficiency virus (HIV) disease who are also substance abusers face a multitude of problems related to their health, addiction, and survival needs. These complex and multiple needs can only be met within a framework of a continuum of comprehensive care (Batki, 1990b; Sorensen and Batki, 1992). However, most alcohol and other drug (AOD) abuse treatment settings do not have the resources to provide the ideal "one-stop-shopping" model of service. Even when such ideal circumstances do exist, coordination and collaboration among a community of providers are still necessary to meet the needs of HIV-infected, substance-abusing clients.

Most AOD abuse treatment settings do not have the resources to provide the ideal "one-stop-shopping" model of service.

Earlier chapters of this Treatment Improvement Protocol (TIP) describe interventions and recommend structures and procedures to provide for the medical, mental health, and social service needs of HIV-infected substance abusers. This chapter focuses on the linkages and collaboration needed to meet these needs more effectively. Suggestions are made for establishing and maintaining linkages among the many organizations -- Federal, State, and local government agencies and local treatment providers -- involved in providing services to HIV-infected AOD abusers.

In the first section, two important Federal initiatives are described that encourage collaboration and the establishment of service linkages among agencies involved in providing or funding services for HIV-infected AOD abusers. These initiatives are: 1) the 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule (45 C.F.R. 96), which applies to all States and treatment providers that receive Federal block grant funds for the provision of AOD abuse services, and 2) the Ryan White Comprehensive AIDS Resources Emergency Act (P.L. 101-381), which provides grants to States and cities affected by the HIV epidemic.

The second section of this chapter reviews the roles of Federal, State, and local government agencies in policymaking and funding services for HIV-infected AOD abusers and describes strategies for establishing and maintaining linkages among government agencies. The role of treatment providers in enhancing collaboration and linkages is also discussed.

Federal Initiatives

1993 Substance Abuse and Treatment Block Grant Interim Regulations

The 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule contains a number of mechanisms for improving service delivery through enhanced collaboration and linkages. (See summary of regulations in Appendix B.) The Federal Government agency

responsible for administering and implementing the Substance Abuse Treatment and Prevention Block Grants: Interim Final Rule is the Center for Substance Abuse Treatment (CSAT).

Requirements for States and treatment providers receiving block grant funds include:

- *Services for pregnant women and women with children*. Programs receiving funding from the block grant's set-aside for pregnant women and women with children must provide primary medical care (including prenatal care and childcare); pediatric care; gender-specific substance abuse treatment and other therapeutic interventions (such as interventions concerned with sexual and physical abuse); and therapeutic interventions for children, as well as case management and transportation services to ensure that clients have access to these services.
- *Services for women*. Programs receiving block grant funds for services to women must provide a "comprehensive range of services to women and their children, either directly or through linkages with community-based organizations," including case management, drug-free housing, and prenatal care.
- *Waiting list management*. States must establish waiting list management programs that systematically report treatment demand and document the provision of interim services for clients who cannot be admitted to treatment within 14 days. At a minimum, such interim services must include counseling about tuberculosis (TB) and HIV.
- *TB services*. Programs must provide TB services, either directly or through linkage with other providers, and develop written procedures for the implementation of these services.
- *HIV early intervention services.* In States with 10 or more AIDS cases per 100,000 population, programs are required to establish linkages with a comprehensive community resource network of health and social service organizations to provide HIV early intervention services.

- *Evidence of coordination.* Programs must demonstrate coordination of treatment and prevention activities with other appropriate services (for example, health, social, correctional, criminal justice, education, vocational rehabilitation, and employment). A memorandum of understanding (MOU) is the suggested method of establishing agreement among agencies.
- *Needs assessments and peer review.* States must conduct statewide needs assessments to document needs and efforts to improve services and perform "independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State." At least 5 percent of programs providing services in the State must undergo peer review.

Ryan White CARE Act

Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve both the quality and availability of care for people with HIV disease and their families. The act provides emergency relief grants to cities and metropolitan areas disproportionately affected by the HIV epidemic (Title I) and formula grants to States for the provision of HIV-related healthcare and support services (Title II). (See Appendix E for a summary of the act.)

To encourage cooperation and coalition building, Title I of the CARE Act requires recipients of funds to set up HIV health services planning councils to plan, develop, and deliver comprehensive outpatient healthcare and support services for people with HIV/AIDS. The CARE Act is administered by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve both the quality and availability of care for people with HIV disease and their families.

The CARE Act requires that membership of planning councils include persons with HIV/AIDS, healthcare providers, community-based service providers, social service agencies, local public health departments, State government representatives, nonelected community leaders, mental health providers, and hospital or healthcare planning agencies, as well as agencies that were grantholders for previous demonstration projects funded by HRSA and recipients of CARE Act Title III funds. The size of the HIV planning council is determined by the chief elected official (CEO) of the eligible metropolitan area.

The Role of the Local HIV Planning Council

Planning councils develop plans for the organization and delivery of HIV-related services and assess the efficiency of the administrative system in charge of allocating funds. Planning councils also make recommendations to the CEO on funding priorities. CARE Act grant recipients must participate in established HIV planning councils.

The structure and functioning of HIV planning councils can vary greatly (Bowen et al., 1992). For example, in San Francisco, the planning council's meetings are open to community members. Nonvoting members can participate in decisionmaking and advocate at council meetings for groups they feel are being overlooked.

Enhancing Linkages Among Government Agencies

Throughout this section on enhancing linkages, the focus is on agencies and what can be done at the organizational level to improve services for HIV-infected substance abusers. However, the importance of individual staff members in the creation and maintenance of linkages cannot be overemphasized. Agencies should have both formal and informal systems for making all staff members aware of existing linkages and the roles of all the agencies involved in the service continuum. In this way, individual clients will be assured of receiving services.

Furthermore, a primary factor in the success of linkages is the relationships that develop between individual staff members from linked organizations. Generally, these relationships

develop in the course of people working together. However, programs should find ways to support and enhance these relationships; for example, program administrators can encourage their staff members to visit other agencies and meet staff with whom they interact. Inservice training or informational presentations on agency functions and the roles of various personnel can help ensure that all resources are being utilized.

Enhancing Linkages at the Federal Level

The Federal Government's role in HIV/AIDS activities is to identify national priorities, provide coordinated funding for State and local activities, and facilitate the development of effective approaches to service delivery. The Federal government's function is to create an environment for collaboration and integration among agencies providing education, prevention, treatment, and research funds for activities related to HIV/AIDS and alcohol and other drug (AOD) abuse. In addressing treatment needs, the Federal role is to promote the integration and coordination of relevant services across Federal, State, and local levels of government, as well as among regulatory agencies, public and private institutions, professional disciplines, and cultural communities.

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Inter- and intra-agency task forces are mechanisms used at the Federal level to promote collaboration and communication. The role of these task forces is to identify the multiple needs of, and public health risks presented by, the HIV-infected substance-abusing population. Activities of such task forces include long-range planning for the distribution of funds to treat and provide other essential services to HIV-infected AOD abusers; cross-training of medical and clinical staff to ensure competence in the assessment, education, and treatment of chemically dependent persons who have HIV infection or AIDS; and developing incentive plans for demonstrated collaboration among State agencies providing AOD, health, and welfare services.

Federal agencies involved with HIV/AIDS have traditionally operated independently of one another as they administer and regulate services related to AOD abuse, HIV/AIDS, and mental health. Funds are disbursed either according to specific categories of care or as block grants. This fragmentation has sent the message that substance abuse, HIV disease, and psychiatric disorders are separate and distinct conditions that can properly be addressed independently of one another.

Service provision at the community level often reflects this isolation of funding streams. For example, providers of primary medical care to HIV-infected persons often do not treat substance abuse problems. AOD abuse treatment settings are rarely equipped to evaluate, diagnose, or treat conditions related to HIV disease. Mental health service providers often are not able to medically treat AOD abusers or persons with (or at high risk for) HIV disease.

Evolution of Federal HIV/AIDS Collaboration

The President's Commission on HIV/AIDS was established in 1989 to increase awareness and understanding of HIV/AIDS and its impact on American society. The commission held public hearings and published a report on the impact of HIV/AIDS in America. In addition, Congress established the National Commission on AIDS to define specific priorities and approaches to dealing with HIV/AIDS. After producing a number of reports and recommendations, the National Commission concluded its work in 1993 when its legislative authorization expired.

The White House Office of National AIDS Policy Coordination was established in 1993 to coordinate Federal agency efforts and provide a high-profile focus on HIV/AIDS. However, individual Cabinet and agency level efforts have been in place for several years. Several Federal agencies, including the U.S. Food and Drug Administration and the Health Resources and Services Administration, have also established AIDS coordination offices or designated officials with responsibility for HIV/AIDS coordination efforts. Also in 1993, an Office of AIDS Research was established by Congress at the National Institutes of Health (NIH) to coordinate institute research activities on HIV/AIDS.

The Substance Abuse and Mental Health Services Administration (SAMHSA) established an AIDS office in 1994. SAMSHA's Office on AIDS, in conjunction with the AIDS offices in CSAT, Center for Substance Abuse Prevention, and the Center for Mental Health Services, is engaged in an ongoing process to further develop HIV-related programs within SAMSHA through:

- A comprehensive and continuing assessment of unmet HIV-related needs of the populations targeted for the agency's services. These populations include people who have alcohol and drug abuse problems, those at risk for alcohol and drug abuse, those with mental health needs, and the seriously mentally ill.
- Analysis of those unmet needs.
- Recommendations for program development and enhancement of SAMSHA programs.

Exhibit 6-1 Federal Agencies With HIV/AIDS Role

Federal agencies with a role in generating funding for services related to HIV/AIDS are listed in Exhibit 6-1. As shown, most agencies are within the U.S. Department of Health and Human Services.

Varying levels of coordination exist within and among different Federal agencies. For example, the Centers for Disease Control and Prevention (CDC) requires that applicants notify State health departments that they have applied for Federal funds. Once grant decisions have been made, Federal funding authorities notify States about decisions to award monies to designated projects in specific localities. Thus, similar projects in the same community may receive grants for the same type of activity, one directly from a Federal agency and another from the State.

Recommended Strategies to Enhance Collaboration at the Federal Level

The consensus panel that developed this Treatment Improvement Protocol recommends the following Federal policy changes to enhance collaboration among Federal, State, and local agencies:

- **Funding policies.** More Federal agencies should adopt funding policies that give priority to entities with demonstrable collaborative projects and provide active technical assistance to organizations that want to engage in collaborative projects. Federal programs that currently require collaboration as a condition of funding include the 1993 Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule, the Ryan White CARE Act's Title I and II programs, and CDC prevention programs.
- **Demonstration projects.** Funding of demonstration projects should be extended beyond 3 years to allow funded projects time to demonstrate successful outcomes. Such a revision would reflect a new Federal collaborative commitment to State and local efforts.
- **Internal communications.** Mechanisms should be created within Federal agencies to ensure communication and coordination among all HIV and AOD abuse programs.
- **Minimum standards.** Minimum program components and standardized protocols of care should be established for programs providing services to substance abusers at various stages of HIV disease.
- **Technical assistance.** Technical assistance in program planning, currently provided by CSAT and CSAP, should be expanded.
- **Training.** Incentives should be provided to national professional health organizations and centers of higher learning to dedicate monies to train graduate students in the health and behavioral sciences in HIV/AOD abuse issues.

Enhancing Linkages at the State Level

State-level collaboration is essential between States and Federal funding agencies, among State agencies, between States and local governments, and between States and community organizations or systems of care. Lack of State collaboration and planning leads to duplication of effort and inefficient use of limited financial resources. For example, many States receive Federal funds that they then distribute to local authorities and community-based organizations. However, some Federal grants go directly to local organizations without the knowledge of the State. Thus, it is difficult for States to have a comprehensive understanding of what, how, and where prevention, education, research, and treatment programs are being developed or established throughout the State.

Although many States have developed planning and collaboration mechanisms to address the care issues presented by HIV-infected substance abusers, such mechanisms may not be effective for a variety of reasons, including shortage of funds, interagency mistrust, a lack of trained personnel, and an absence of political directives requiring collaboration. As a result, programs may develop in a reactive, piecemeal, fragmented fashion. State agencies may also resist confronting the fiscal consequences of HIV disease. The establishment of formal relationships among State agencies to encourage the development of integrated and coordinated services for HIV-infected persons with AOD abuse would help to overcome some of these barriers. In particular, linkages should be established between State AOD and HIV planning committees.

Although many States have developed planning and collaboration mechanisms to address the care issues presented by HIV-infected substance abusers, such mechanisms may not be effective for a variety of reasons, including:

- Shortage of funds
- Interagency mistrust
- A lack of trained personnel
- An absence of political directives requiring collaboration.

Recommended Strategies for Enhancing State-Level Collaboration

The following are measures that States could implement to improve State-level collaboration.

- **Specific objectives.** States should set specific coordination and planning objectives that are consistent with the requirements of federally funded programs. These objectives should include protocols and minimum program components for the comprehensive care of HIV-infected substance abusers.
- **Community assistance.** States should provide guidelines to communities on how to develop coordinated programs and assist communities in developing coalition-building strategies.
- **Cross-training.** States should conduct cross-training of staff of key State departments.
- **Resource manual.** States should develop a statewide HIV/AOD abuse resource manual that is updated quarterly, a comprehensive directory of AOD/HIV contracting agencies, and a uniform database that is consistent among providers.
- **Facilitate collaboration.** States should make every effort to facilitate collaboration among departments that provide related services.

Enhancing Linkages at the Local Level

The purpose of collaboration at the local level is to facilitate the development of comprehensive service delivery systems that address the medical and psychosocial needs of HIV-infected AOD abusers. Linkages need to be created both "up" to Federal and State authorities and "down" to providers such as hospitals and community-based organizations.

Numerous barriers exist to collaboration at the community level. Agencies may lack knowledge of existing resources. Differing treatment philosophies and intense competition for scarce resources may breed mistrust among agencies. Some communities lack a mechanism such as a consortium to provide a forum for the development of linkages.

A consortium is a key mechanism in bringing about community-level collaboration. By bringing together representatives of government agencies, treatment providers, and community-based organizations, a consortium can facilitate interagency communication and act as a catalyst for a variety of activities. A consortium can be a vehicle for technology transfer and mentoring among providers. It can be especially useful in supporting newer, smaller community-based organizations.

A consortium collaboration process can be used to produce a long-term local plan for the provision of services to HIV-infected AOD abusers, taking into consideration community-specific needs such as language, cultural relevance, and community empowerment. By involving hospital-based HIV-related primary care and AOD abuse treatment institutions and promoting cross-training among AOD abuse treatment and HIV primary care, social services, and mental health providers, a consortium can facilitate the development of a network of highly trained professional staff capable of responding to the multiple, complex needs of HIV-infected substance abusers. A consortium might also establish an HIV early-intervention plan that included an HIV early- intervention medical center with a specific unit for AOD abuse treatment. Some consortia become involved in advocacy and in educating legislators about the needs of HIV-infected AOD abusers.

A consortium may be a local government-led body, a community-based forum directed largely by providers, or an effort coordinated by an advocacy group. Consortium membership should reflect the ethnic, gender, and sexually oriented diversity of the local community. Communities receiving funding under Title I of the Ryan White CARE Act must set up multidisciplinary planning councils (see Ryan White CARE Act, above).

A consortium can facilitate the development of a network of highly trained professional staff capable of responding to the multiple, complex needs of HIV-infected substance abusers.

Recommended Strategies for Enhancing Community Collaboration

The following strategies may be used by local governments to achieve collaboration among AOD-abuse and HIV/AIDS-treatment providers.

- **A representative group with designated goals.** A collaborative body should be established that is driven by a designated goal or set of goals. Some consortia focus on making funding decisions to meet identified needs; others concentrate on identifying specific needs that, if met, would help create a comprehensive service system. Still others carry out advocacy efforts with government agencies.
- **Cross-training.** Cross-training should be implemented to develop professional competence in HIV and AOD abuse issues. Cross-training may be sponsored by State entities, local governments or their agents (with Ryan White funding), or community-based organizations through memorandums of understanding (MOUs) or service agreements.
- **Technical assistance.** Technical assistance should be given to providers so they can develop their ability to locate and successfully apply for State and Federal grants for prevention, research, and direct services.

Enhancing Collaboration Among Treatment Providers

In a comprehensive, coordinated system of care for HIV-infected substance abusers, AOD abuse treatment facilities are linked with collateral providers of medical, psychosocial, and other services. Linkages are typically established and funded with the assistance of local, State, and Federal entities. MOUs can be used to define and establish working relationships among agencies. See box on interagency agreements and Appendix H, Sample Memorandum of Understanding. Such agreements clarify relationships, roles, and responsibilities.

It is appropriate that AOD abuse treatment programs coordinate HIV care for their clients because program staff understand not only the chronic, relapsing, and progressive nature of addictive disorders but also the typical behavior patterns and communication styles of AOD abusers. Many HIV care providers lack training and experience in dealing with people who need

AOD abuse treatment. Substance abusers in treatment generally feel more understood, accepted, and respected in AOD abuse treatment settings (Umbricht-Schneiter et al., 1994). These clients are sensitive to gestures, tone of voice, and other verbal and nonverbal messages signifying rejection or disapproval. When such messages are picked up, clients are less likely to meet appointments and follow through with self-care.

Recommended Strategies for Improving Treatment-Level Linkages

Mechanisms for securing linkages among providers include:

- **Case management.** Institutional efforts to link functionally separate systems of care are essential to facilitating individual case management through which clients are linked to a wide spectrum of needed services. (Case management is discussed in Chapter 5.)
- **Educational outreach and cross-training.** Cross-training on HIV and AOD abuse issues for professionals in primary healthcare, substance abuse treatment, social services, and mental healthcare is essential to the development and coordination of a continuum of services for substance abusers with HIV disease. The substance abuse treatment community has much to contribute to the education of professionals, community groups, private organizations, and government agencies about the interface between HIV/AIDS and substance abuse. Becoming a resource to the community through providing inservice training on substance abuse treatment issues and HIV disease is a way of establishing connections and gaining credibility with other healthcare professionals.
- **Joint ventures.** AOD treatment facilities can cope with reduced revenues by linking with other treatment programs to obtain contracts with insurance companies and Medicaid as primary providers for the care of HIV-infected substance abusers.
- **Use of volunteers.** Volunteers can be helpful in performing ancillary services such as transporting or accompanying clients to appointments,

providing childcare, serving as interpreters, and helping to negotiate bureaucracies.

- **Interagency Agreements**
- Agencies providing services to HIV-infected AOD abusers are advised to set up formal interagency agreements that clarify the institutional responsibilities of all the organizations from which clients will be receiving services. (Such agreements are currently being developed on a patient-by-patient basis.) These agreements may be called mutual service agreements, linkage agreements, or memorandums of understanding (MOUs).
- **Agencies involved in interagency agreements may include:**
- HIV/AIDS service organizationsHIV/AIDS healthcare clinicsPrimary care physiciansAOD treatment and support services providersSocial services agenciesPublic health departments (especially for CARE Act grants)Home healthcare agenciesAOD prevention programsPrenatal and postnatal care providersChildcare agenciesEntitlement programsRespite care providersAftercare providers.
- An interagency agreement should describe the specific services each agency is expected to provide and the frequency with which services are to be provided. The agreement should also identify, by name and title, a contact person in each agency. Agencies should also devise and agree to an interagency communication mechanism. To avoid duplication of services (where more than one agency is providing case management services to the same client), the interagency agreement should describe a procedure for designating a "lead agency" for each patient; the lead agency is responsible for providing the case manager or case coordinator and for convening interagency case conferences.
- Other issues that may need to be dealt with in interagency agreements include policies on sharing client information among agencies and the

limits of each agency's responsibilities toward an individual client. Including such issues in a formal agreement may help to prevent disputes arising between agencies over "turf." It is recommended that each agency involved in an interagency agreement design a checklist of the services it has agreed to provide. The list can be used as a record of what services were provided to a client and when; it may be shared with the patient's case manager and with other provider agencies if appropriate.

- Service agreements may be needed to cover medical emergencies arising outside of a clinic's service hours. Issues to be covered in these agreements may include preferential services for clients covered by the MOU, attending privileges at private or public hospitals for medical staff of AOD abuse treatment facilities, designation of registered nurses to act as liaisons between AOD abuse treatment providers and hospitals, and shared on-call status of medical staff after treatment hours. Several AOD abuse treatment facilities may pool their resources for this purpose.
- Such service agreements should also address the need for a system to ensure that AOD-abusing clients with advanced AIDS have access to treatment when they become unable to walk or to monitor and follow through with treatment regimens. Agreement should be reached on care options such as the use of visiting public health nurses, home hospices, and mobile clinics that dispense medication. (See Chapter 5 for a discussion of home healthcare).
- **Coalition Building**
- Coalition building is one of the most effective ways of addressing the complex issues involved in meeting the social services needs of HIV-infected AOD abusers. Coalitions may take a variety of forms (such as consortia or task forces) and may focus on a variety of goals (such as advocacy or education). The following suggestions may help in creating strong, active, effective coalitions. Coalitions should include a broad range

of people, among them healthcare professionals, clients who use AOD/HIV services, community leaders, and political officials.HIV and AOD abuse treatment professionals should actively participate in coalitions concerned with treatment and social services.Coalitions should encourage and facilitate consumer involvement in service planning and delivery. For example, clients should be involved in helping to identify gaps in services. Empowerment is not only important for clients, but it also helps to advance the cause of AOD/HIV services.Alliances with religious organizations may be particularly valuable in certain communities. In many African-American communities, churches can provide an often untapped pool of potential volunteers. Churches may also be able to provide much-needed space for AOD/HIV programs.Appealing to people's enlightened self-interest is important when working with coalitions. For example, if an AOD program is interested in closing some of the numerous liquor stores that are close to a particular high school, it might be helpful to get parents of students at the school involved in the effort.

- **Maintaining linkages.** Regular multidisciplinary interactions are important to maintaining and strengthening linkages. These can include weekly, interdisciplinary inpatient and outpatient rounds, interagency inservice training sessions, weekly HIV and substance abuse task force meetings of community- and hospital-based administrators and key clinicians, and monthly case conferences. It is also helpful when staff members visit settings that are frequently used by their clients, such as halfway houses, hospices, and hotels.

TIP 15: Chapter 7 - Key Legal Issues in HIV/AIDS and AOD Abuse Treatment[1]

Staff and managers of alcohol and other drug (AOD) abuse treatment facilities must be aware of legal requirements that arise when providing services to clients who are HIV infected, perceived to be HIV infected (based upon conjecture, myth, fear, or stereotype), or diagnosed with AIDS. Also relevant are legal requirements for dealing with infectious diseases such as tuberculosis (TB) or sexually transmitted diseases (STDs) that are often associated with HIV/AIDS.

Legal provisions are designed to ensure client access to care, prevent discrimination, maintain client trust, handle communications among providers while maintaining client confidentiality, and provide optimal medical and treatment services to clients with HIV/AIDS and other infectious diseases.

Under three headings, this chapter addresses legal issues relevant to the treatment of HIV-infected AOD abusers: access to treatment, confidentiality, and HIV counseling and TB testing.

Access to treatment. Discrimination against people with HIV/AIDS has arisen in a wide range of service settings. Problems have included denial of services, provision of inadequate care, and violation of confidentiality regarding clients' HIV/AIDS status. Depending on the circumstances, involuntary termination of care may also be classified as a discrimination issue.

Rules governing access to treatment are included in various AIDS-specific antidiscrimination laws, general antidiscrimination laws, and provisions limiting involuntary termination of care by a treatment program. Federal, State, and local AIDS antidiscrimination laws have been developed in response to AIDS-related discrimination. Other antidiscrimination statutes have been interpreted and expanded to cover HIV/AIDS. Agencies should consult counsel to determine relevant State and local laws.

Confidentiality. Maintaining strict confidentiality of sensitive client information is crucial to the client-provider therapeutic relationship in AOD abuse treatment. Confidentiality also assists

efforts to carry out counseling and testing for HIV/AIDS, TB, and STDs, as well as contact tracing/partner notification services.

Maintaining strict confidentiality of sensitive client information is crucial to the client-provider therapeutic relationship in AOD abuse treatment.

Confidentiality regulations and statutes are specific to drug treatment services and to HIV/AIDS-related services. The latter cover HIV counseling and testing (for example, voluntary and mandatory testing, informed consent, and anonymous and confidential testing), TB testing and treatment, and STD testing and treatment.

Confidentiality provisions are found in both Federal and State laws and regulations. Federal regulations are designed to ensure quality treatment for AOD clients in facilities receiving Federal assistance. State confidentiality requirements are most commonly directed at protecting information about HIV/AIDS status in the HIV-counseling-and-testing as well as in care-providing settings.

HIV counseling and tuberculosis testing. The 1993 Federal Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule requires States to ensure that counseling and education about HIV and TB are provided as part of the "interim services" they must provide for individuals awaiting treatment for intravenous drug abuse (45 C.F.R. §96.126). In addition, programs are required to provide TB services, including development of protocols "to prevent the transmission of tuberculosis, such as screening patients" (45 C.F.R. §§96.127, 96.128). Many States also require these services. (See section on TB screening in Chapter 3.)

In addition, Federal regulations for methadone maintenance programs require HIV counseling of clients (21 C.F.R. 291 §291.505(i)(C)) and require TB testing as part of each client's initial medical evaluation (21 C.F.R. §291.505(d)(3)).

The incidence of TB has increased dramatically in recent years, mostly in geographic areas and demographic groups that have a high incidence of HIV/AIDS, including the AOD abuse

population. Cases of multidrug-resistant TB (MDR-TB) are also increasing; most of these cases occur in persons with HIV/AIDS.

Because of the high correlation between TB, HIV infection, and AOD abuse, treatment programs should be aware of Federal and State requirements with regard to counseling and testing, reporting of HIV/AIDS and TB to public health authorities, providing treatment for HIV/AIDS and TB (preventive therapy for nonactive cases as well as treatment of active TB), and dealing with noncompliant TB-positive clients. Treatment programs also should be aware of their legal obligations to inform individuals that they may have been unknowingly exposed to contagious TB ("duty to warn").

Treatment programs also should be aware of their legal obligations to inform individuals that they may have been unknowingly exposed to contagious TB ("duty to warn").

Access to Treatment

Two Federal laws include prohibitions on AIDS-related discrimination: the 1990 Americans with Disabilities Act and the 1973 Rehabilitation Act. In addition to these Federal statutes, most States and many city and county governments have also enacted laws, statutes, and regulations prohibiting AIDS-related discrimination. AOD programs should consult counsel to determine which Federal laws and State laws and regulations are applicable to them.

Americans with Disabilities Act

The 1990 Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment (Title I) and in public accommodations (Title II), as well as in public transportation, State and local government services, and telecommunications. Under the ADA, the term "people with disabilities" includes persons who are HIV infected or perceived to have HIV infection or AIDS, and those diagnosed with AIDS. "Public accommodations" are defined as private entities that serve the public, including treatment programs and other healthcare

facilities. ADA prohibits requiring individuals to be tested for HIV as a condition of admission to treatment.

Under the Americans With Disabilities Act the term "people with disabilities" includes persons who are HIV infected or perceived to have HIV infection or AIDS, and those diagnosed with AIDS. The act prohibits requiring individuals to be tested for HIV as a condition of admission to treatment.

State HIV counseling and testing statutes (discussed in the Confidentiality section of this chapter) outline limited conditions that allow for mandatory HIV testing. ADA is the only Federal law that addresses conditions for carrying out HIV testing.

Additionally, ADA prohibits refusal to admit for treatment persons with HIV/AIDS or persons perceived to be HIV infected who are otherwise eligible. Providing differential treatment that is less adequate or limiting because of the client's real or perceived HIV/AIDS status is also prohibited.

AOD treatment providers are required by ADA to make some accommodations to enable individuals with HIV/AIDS to participate in and benefit from treatment services; however, such accommodations are not required to the extent that the basic nature of services offered is changed or that undue financial hardship is incurred.

ADA prohibits segregating persons with HIV/AIDS or providing them with differential treatment in order to protect others from infection. Rather, alternative measures, such as infection control procedures and staff education, must be undertaken to prevent the spread of infection. Preventive guidelines in these areas have been developed by the Centers for Disease Control and Prevention (CDC 1987b, 1988; Occupational Safety and Health Administration, 1992).

Rehabilitation Act

The 1973 Rehabilitation Act has been interpreted to prohibit discrimination against persons with disabilities, including persons with HIV/AIDS. Entities covered include Federal agencies and

recipients of any Federal funding (either contractors or grantees). Most AOD treatment and health agencies are classified as grantees under the 1973 Act.

The 1973 Rehabilitation Act has been interpreted to prohibit discrimination against persons with disabilities, including persons with HIV/AIDS. Entities covered include Federal agencies and recipients of any Federal funding (either contractors or grantees). Most AOD treatment and health agencies are classified as grantees under the 1973 Act.

Involuntary Termination of Care

State laws outline both general requirements for services and care that agencies must provide to clients and those circumstances under which involuntary termination of care is allowable. These State provisions define an agency's responsibility to treat people, and conditions delimiting involuntary termination of care; the definition deals with due process for clients and agencies' compliance with medical malpractice rules. State laws do not allow AOD treatment agencies to terminate care or fail to serve clients because of their HIV/AIDS status.

Under these State provisions, clients who resist receiving care and disrupt the clinic's operations may be denied services if their behavior is defined as unreasonable and if accommodating such behavior would substantially change the nature of the services offered by the clinic. However, programs should seek counsel to determine the specific State laws and requirements that define compliance with this requirement.

The only Federal regulations relating to involuntary termination of care are the regulations governing the provision of methadone maintenance treatment, which specify circumstances under which a client's noncompliance with treatment can result in denial of services. Given the high percentage of AOD clients who are HIV-infected, these regulations have possible implications for limiting access to AIDS-related prevention and care services provided in AOD settings or facilitated by AOD program staff in other settings.

Confidentiality

Strict confidentiality of client information, including information about HIV/AIDS status, is crucial to the maintenance of the therapeutic relationship. Clients rely upon this standard of confidentiality when they enter care, and while in treatment they continue to trust that their medical and personal records will be protected from unwanted and unwarranted disclosure.

From their origin in the tradition of professional ethics regarding the provider-client relationship, confidentiality standards have evolved into rights that are protected by both Federal regulations and State laws. Maintaining confidentiality about client HIV/AIDS status is primarily governed by State provisions. Federal regulations on confidentiality do not govern confidentiality of HIV/AIDS status but are relevant because they relate to maintaining confidentiality of information about a client's status in an AOD abuse treatment program.

Federal laws and corresponding regulations require the maintenance of strict confidentiality of information about persons receiving AOD prevention and treatment services (i.e., 42 U.S.C. §290 dd-3, ee-3; 42 C.F.R., Part 2). Information protected under these confidentiality provisions includes any information about a client in an AOD program. While the regulation does not specifically prohibit release of information about a client's HIV/AIDS status, any release of such information that would directly or indirectly identify that individual as a client is prohibited. Therefore, release of information about a client's HIV/AIDS status that also revealed the client's status as an AOD treatment client would be covered under Federal confidentiality laws.

Release of information about a client's HIV/AIDS status that also revealed the client's status as an AOD treatment client would be covered under Federal confidentiality laws.

The purpose of these laws and regulations is to protect client privacy in order to secure participation in treatment. In some instances, these confidentiality requirements place restrictions on communication that are more severe than generally required by the standards of either doctor-patient confidentiality or attorney-client privilege.

Unless otherwise noted, AOD confidentiality provisions cover any program that provides treatment, counseling, and/or assessment and referral services for persons with AOD problems.

The regulations apply only to programs that receive Federal assistance. However, "Federal assistance" is defined broadly to include indirect forms of Federal aid such as tax-exempt status or State or local government funding that in whole or part derives from Federal sources.

Federal confidentiality regulations outline the circumstances in which disclosure of information about clients in AOD programs is prohibited, exceptions under which disclosure is allowed, requirements for obtaining clients' written informed consent to the disclosure of information, and requirements regarding the sharing of information with outside agencies that provide program services.

Prohibition of Disclosure

Federal regulations prohibit disclosure of records or other information on any client in a federally assisted AOD abuse treatment program, except under certain limited conditions (see below, Exceptions to the Provision of Disclosure). Disclosure is prohibited regardless of whether the person seeking information, already has it, has other means of obtaining it, enjoys official status (e.g., a judge or law enforcement officer), has obtained a subpoena or warrant, or is authorized by State law to obtain the information. The Federal regulations invalidate any less stringent State laws governing disclosure of information about patients in AOD programs; however, States may have confidentiality regulations that are stricter than Federal requirements. Redisclosure of information (i.e., transmitting to a third party confidential information received in compliance with procedures) is prohibited unless done in compliance with Federal regulations.

Exceptions to the Prohibition of Disclosure

Federal law permits limited disclosure of information about identified clients in AOD abuse programs with written client consent if the consent form complies with Federal regulations. In addition, there are several conditions under which disclosure may be made without client consent.

Exceptions to the prohibition of disclosure include disclosures made in the following instances:

- As part of internal program communications
- In response to a medical emergency
- In response to a court order following a court hearing in which disclosure is authorized
- In response to a crime committed at the treatment program or against program personnel
- In the course of reporting child abuse
- Pursuant to a qualified service organization agreement
- In providing information that does not associate the client with AOD abuse and does not identify the client as being in AOD treatment
- For research, audit, or evaluation purposes.

Except for the first exception involving written consent, none of the above situations require written client consent. Following is a more detailed discussion of written client consent and each of these exceptions.

Written Client Consent

A proper written consent form must contain all of the following (as detailed in Federal confidentiality regulations, 42 C.F.R. §2.31):

- The name, or a general description, of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the client who is the subject of the disclosure
- The purpose of or need for the disclosure
- The amount and nature of the information to be disclosed
- A statement that the client may revoke (take back) consent for the disclosure at any time, except to the extent that the program has already

acted on it (A specific length of time or "cooling off" period is not required before the disclosure occurs.)

- The date, event, or condition upon which the consent expires if not previously revoked
- The signature of the client (In the case of a minor, some States require the signature of a parent.)
- The date on which the consent is signed.

Following are a number of items that deserve further explanation, including the purpose of the disclosure and how much and what kind of information will be disclosed, the client's right to revoke the consent statement, expiration of the consent form, required notice against rereleasing information, and discretion of agency to release information authorized by the consent form.

Purpose of disclosure/information that will be disclosed. These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). For example, it would be improper to disclose everything in a client's file if the recipient of the information only needs a specific item of information.

In completing a consent form, it is important to determine the purpose or need for the communication. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed and to tailor the disclosure to what is essential to accomplish the identified need or purpose.

For example, if a client needs documentation of participation in a treatment program to be eligible for a benefit (such as home relief), the purpose of the disclosure would be "to obtain home relief benefits" and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Jane Doe [the client] is participating in treatment at the XYZ Program." No other information about the client would be released.

In completing a consent form, it is important to determine the purpose or need for the communication. It is then easier to determine how much and what kind of information will be disclosed and to tailor the disclosure to what is essential to accomplish the identified need or purpose.

Client's right to revoke consent. The general consent form authorized by Federal regulations permits clients to revoke consent at any time (orally or in writing); the consent form must include a statement to this effect.

If a program has already made a disclosure prior to the revocation, the program has *acted in reliance* on the consent (i.e., the program was relying on the consent form when it made the disclosure). Therefore, the program is not required to try to retrieve the information it has already disclosed. Federal regulations state that acting in reliance includes the provision of services while relying on the consent form to permit disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party that pays the bills other than the client's family or the treatment agency.) Thus, a program can bill the third-party payer for past services provided before consent was revoked. However, a program that continues to provide services after a client has revoked a consent form authorizing disclosure to a third-party payer does so at its own financial risk.

Expiration of consent form. The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)).

It is better practice to think through how much time the consent form should run than to have all consent forms expire within a standard timeframe (e.g., 60 or 90 days). When uniform expiration dates are used, agencies can find that they have a need for a disclosure but that the client's consent form has expired. In such a situation, at the least, the client must come to the agency again to sign a new consent form. At worst, the client has left or is unavailable (e.g., in the hospital or incarcerated), and the agency cannot make the disclosure.

The consent form does not need to contain a specific expiration date but may instead specify an event or condition. For example, if a client is being referred to a specialist for a single appointment, the consent form should provide that it will expire after he or she has seen "Dr. X."

Required notice against rereleasing information. Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32). This statement, *not the consent form itself*, should be explained and provided to the recipient of the information at the time of disclosure or earlier. The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. (However, a client may sign a consent form authorizing such a redisclosure.)

Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations.

Discretion of agency to determine release of information authorized by consent form. The fact that a client has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)). In most cases, the decision whether or not to make a disclosure pursuant to a consent form is within the discretion of the program unless State law requires or prohibits disclosure once consent is given. In general, it is best to use the following rule: disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

Internal Program Communications

Exhibit 7-1 Extract from Federal Regulations Concerning

(more...)

Federal regulations allow staff within a program to share client information among themselves if their AOD abuse work requires it (see Exhibit 7-1).

There are circumstances in which Federal law allows the sharing of information among units within a larger entity. To comply with this provision, the unit with which the AOD program can share information must have direct administrative control over the AOD program. Agencies should be aware that if information sharing occurs, they must ensure that each unit complies with its responsibility to maintain confidentiality of client information. Agencies should consult with counsel before setting up such an internal communications system.

Medical Emergencies

In the course of a medical emergency, a program may disclose information about a client to public or private medical personnel (but not to nonmedical personnel) "who have a need for information . . . for the purpose of treating a condition which poses an immediate threat to the health of any individual and requiring immediate medical intervention." The regulations define "medical emergency" as a situation that poses an immediate threat to the health of any individual and requires immediate medical intervention (§2.51). Thus, AOD and AIDS-related information can be provided to medical personnel in the course of providing appropriate treatment to a client in a medical emergency. However, this information cannot be provided to nonmedical personnel because they have no such "need to know." Medical personnel refers to persons with medical degrees.

Court-Ordered Disclosures

A State or Federal court may issue an order for an AOD abuse treatment program to make a disclosure of client-identifying information that would otherwise be prohibited. However, the court must follow procedures and make determinations as required by Federal regulations and

State laws. Court-ordered release of AOD information is governed by Federal regulations; corresponding State provisions that are less stringent are preempted by the Federal regulations, but more strict State provisions do apply. No Federal regulations address release of AIDS-related information; many States have strict requirements prohibiting release of AIDS-related information through court order. Programs should consult counsel to determine what laws apply in their States.

A State or Federal court may issue an order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue one of these authorizing orders only after it follows special procedures and makes determinations required by the regulations. A subpoena, search warrant, or State arrest warrant, even when signed by a judge, is not alone sufficient to require or even to permit a program to disclose information (§2.61).[2]

A subpoena, search warrant, or State arrest warrant, even when signed by a judge, is not alone sufficient to require or even to permit a program to disclose information.

Before a court can issue a court order authorizing a disclosure about a client, the program and any clients whose records are sought must be given notice of the application for the order and opportunity to make an oral or written statement to the court.[3] A client's oral or written statement can be made by a person acting on the client's behalf, such as an attorney.

Generally, the application and court order must use fictitious names for any known client, and all court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the patient, on the doctor-patient or counselor-patient relationship, or on the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of

obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury.
- The records sought are likely to contain information of significance to the investigation or prosecution.
- There is no other practical way to obtain the information.
- The public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients.

When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. If the program is a governmental entity, it must be represented by counsel (§2.65(d)).

There are limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§§2.64(e), 2.65(e)).

The court may order disclosure of "confidential communications" by a client to the program only if the disclosure fills at least one of the following conditions:

- It is necessary to protect against a threat to life or of serious bodily injury.
- It is necessary to investigate or prosecute an extremely serious crime (including child abuse).

- It is needed in connection with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor. . . .") (§2.63).

Crimes on Program Premises or Against Program Personnel

When a client has committed or threatened to commit a crime on program premises or against program personnel, Federal regulations permit the program to seek the assistance of or report the crime to a law enforcement agency.

In such a situation, without any special authorization, the AOD abuse treatment program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client of the AOD program. State laws govern the reporting of HIV/AIDS status to law enforcement agencies.

Reporting child abuse and neglect. All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. Although many State statutes are similar, each State has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

When a client has committed or threatened to commit a crime on program premises or against program personnel, Federal regulations permit the program to seek the assistance of, or report the crime to, a law enforcement agency.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (usually telephone) report and many now have toll-free numbers to facilitate reporting. (Half the States require both oral and written reports.) All States extend immunity from prosecution to persons reporting child abuse and neglect. (In other words, a person who reports child abuse or neglect cannot be brought into court.) Most States provide for penalties for failure to report.

Most States now require not only physicians but also educators and social service workers to report child abuse.

Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. Thus, if a client reveals to program staff that he or she has neglected or abused children, that fact may well have to be reported to State authorities. Note, however, that this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the client consents or the appropriate court issues an order under subpart E of the regulations.

Because of the variations in State laws, programs should consult an attorney familiar with the law in their States to ensure that their reporting practices are in compliance.

Qualified service organization agreements. If an AOD program routinely needs to share certain patient information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA). This is a written agreement between a program and an entity providing services to the program. A QSOA is not the same as an interagency agreement or memo of understanding unless (1) those instruments embody an agreement between an AOD abuse treatment program or an entity providing services to the program and (2) those instruments contain the language that Federal regulations require a QSOA to contain.

With a QSOA, the person or agency does the following:

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, he or she is fully bound by Federal confidentiality regulations

- Promises that, if necessary, he or she will resist any efforts to obtain access to patient records except as permitted by these regulations (42 C.F.R. §§2.11, 2.12(c)(4)).

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. An example is when laboratory analyses or data processing are performed for the program by an outside agency. A QSOA is not permitted as a mechanism for sharing client information with an entity that is providing services to specific clients.

Communications that do not disclose patient-identifying information. Federal regulations permit programs to disclose information about a client if the information is not "patient identifying," that is, information that identifies someone as an AOD abuser. Thus, a program may disclose information about a client if that information does not identify him or her as an AOD abuser or support anyone else's identification of the client as an AOD abuser. There are two basic ways a program may make a disclosure that does not identify a client.

Aggregate information. A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its population. For example, a program could tell a newspaper that in the last 6 months it screened 43 offenders, 10 female and 33 male.

Release of information that does not indicate or imply AOD status of client. A program can communicate information about a client in a way that does not reveal the client's status as an AOD abuse patient (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as AOD abuse may disclose information about a particular client as long as the fact that the client has a substance abuse problem is not revealed. A program that is part of a general hospital could have a counselor call the police about a threat a client made, so long as the counselor does not disclose that the client has an AOD abuse problem or is a client of the AOD abuse treatment program.

Programs that provide only AOD abuse treatment services or that provide a full range of services but are identified by the general public as AOD programs cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the client as someone in the program. However, a freestanding program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as an AOD abuser.

Disclosure for Research, Audit, or Evaluation Purposes

Federal regulations permit AOD programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, provided that certain safeguards are met (42 C.F.R. §§2.52, 2.53).

Federal regulations permit AOD programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, provided that certain safeguards are met.

Research. AOD programs can disclose patient-identifying information to persons conducting "scientific research" if the program director determines that the researcher (1) is qualified to conduct the research, (2) has a protocol under which patient-identifying information will be kept in accordance with the regulations' security provisions (see §2.16), and (3) has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects clients' rights. Researchers are prohibited from identifying any individual client in any report or otherwise disclosing any client identities except to the program.

Audit and evaluation. Approved entities performing an audit or evaluation (e.g., utilization or quality control review) may have access to client records on the program's premises. Approved entities include Federal, State, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third-party payments to a program, and

peer review agencies. Any person or entity that reviews client records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose client information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(a), (c), (d)).

Approved entities may also copy or remove records only if they agree in writing to maintain patient-identifying information in accordance with the regulations' security requirements (see §2.16), to destroy all patient-identifying information when the audit or evaluation is completed, and to redisclose client information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(b)).

Any other person or entity who is determined by the program director to be qualified to conduct an audit or evaluation and who agrees in writing to abide by the restrictions on redisclosure can review client records. However, only approved entities can copy or remove records.

Followup research. Research that follows clients after they leave treatment presents a special challenge under Federal confidentiality regulations. The AOD program researcher or evaluator who seeks to contact former clients to gain information about their status after leaving treatment has to take care that this is done without disclosing to others any information about the former clients' connection to the AOD abuse treatment program.

If followup contact is attempted over the phone, researchers must ensure that they are talking to the client before they reveal who they are or that there is a connection to AOD abuse treatment. For example, asking for Sally Jones when her husband or child answers the phone and announcing that the caller is from the XYZ AOD Program (or the Drug Research Corporation) violates the regulations. Another approach is for the program (or research agency) to form another entity, without a hint of AOD treatment in its name (e.g., Health Research, Inc.), that can contact clients without worrying about disclosing information in the contact itself. However,

when clients are being called by this entity, the researchers still must ensure that they are speaking to the client before revealing any connection to AOD abuse treatment.

If followup is done by mail, the return address on the letter should not disclose any information that could lead anyone seeing the envelope to conclude that the addressee was in AOD abuse treatment.

State Confidentiality Laws

A variety of State confidentiality laws may affect how services are provided to AOD abuse clients. These laws may control the release of medical records, limit the ability of persons to testify in court based on information obtained when providing professional services (*testimonial privilege*), or prohibit disclosure of information regarding specific medical conditions such as drug abuse or HIV/AIDS. Service providers and AOD treatment staff should consult with legal counsel to determine which State confidentiality laws affect their practices, and develop protocols and training programs to ensure that these laws are followed.

There is a wide range of State HIV/AIDS confidentiality laws. A number of States include HIV/AIDS under STD confidentiality protection statutes and regulations. All States require informed consent for an HIV test. All States require reporting of AIDS cases; most States require reporting of persons testing HIV positive, either by name or by means of other identifying information.

State HIV/AIDS confidentiality provisions typically cover:

- HIV counseling and testing
- Requirements for obtaining consent prior to HIV testing
- Provisions for anonymous and confidential HIV testing
- Reporting of HIV infection and/or AIDS to public health authorities
- Recordkeeping of HIV/AIDS results and medical records
- Notification of partners of HIV-positive patients
- Disclosure of HIV/AIDS-related client information.

Confidentiality considerations also arise under "duty-to-warn" situations, in which programs are faced with the dilemma of reporting a client's threat to inflict harm to self or others. Duty-to-warn provisions may be addressed by State law or court interpretation.

HIV Counseling and Testing

AOD abuse treatment programs increasingly are providing HIV counseling and testing services to clients. Individuals identified as HIV positive can obtain early treatment that can ameliorate the opportunistic infections associated with HIV infection and may delay the onset of AIDS. Nevertheless, some clients choose not to be tested for HIV infection. Clients have a right to refuse HIV testing and cannot be denied access to care or continued treatment services if they exercise this right.

A wide range of State and local laws specify how HIV testing and counseling are to be conducted. In addition, CDC guidelines (CDC, 1987a) state that all clients being tested for HIV should receive pre- and posttest counseling. Pretest counseling should provide information about consent, testing procedures, interpretation of test results, and requirements for the reporting of test results. In addition, pretest counseling should cover how HIV is transmitted, how clients can reduce their risk either of becoming infected or of infecting others, and how HIV/AIDS can be treated.

Individuals should be notified about their HIV status in person during posttest counseling, not by mail or over the phone. Face-to-face notification is critical because of the emotional stress associated with receiving HIV results. In addition, it is essential that counseling about risk reduction, partner notification, and treatment take place when the client is notified of the test results.

Some States require mandatory testing of certain individuals, such as mentally ill or mentally retarded patients, marriage license applicants, sex offenders, and persons convicted of illegal use of hypodermic instruments. Two States (Rhode Island and Washington) currently mandate HIV testing for persons convicted of possession of a hypodermic instrument associated with

intravenous drug use or convicted of a drug offense determined to be associated with the use of hypodermic needles. Treatment programs should determine their State's requirements, particularly as they relate to injection drug users.

Client Consent

All States require that clients give consent prior to HIV testing. States vary in their requirements for oral or written consent; consent must be written in some States. Oral consent typically must be documented in the client's medical record. Exceptions to this rule include Federal exceptions outlined above regarding disclosure of information about persons receiving AOD services. (Information includes HIV/AIDS status if such information is included in a client's AOD records and revealing it would reveal that the individual was a client in an AOD program.) (See above, Exceptions to the Prohibition of Disclosure.) Additional exceptions are outlined below in the section, Disclosure of AIDS-Related Information.

In some States, minors can give informed consent for HIV testing without parental agreement. In those States that require reporting of HIV-positive cases, informed consent requirements should include information about the provision of information on HIV/AIDS status to public health authorities.

Pretest HIV counseling should provide information about consent, testing procedures, interpretation of test results, and requirements for the reporting of test results. It should also should cover how HIV is transmitted, how clients can reduce their risk either of becoming infected or of infecting others, and how HIV/AIDS can be treated.

Confidential and Anonymous HIV Testing

An HIV test can be provided either confidentially or anonymously. In confidential testing, the client is identified and informed of the test result; measures are taken to restrict access by third parties to information about the client's test result (see Recordkeeping, below). In anonymous testing, no client-identifying information is obtained. State laws often require that clients be

offered the option of confidential or anonymous testing and have the benefits of each explained. Twenty-seven States have laws that specifically provide the option of anonymous HIV testing.

Reporting HIV/AIDS Information to Public Health Authorities

State laws govern requirements on reporting of HIV infection and/or AIDS cases to public health authorities. Most States require reporting of HIV infection; all States require reporting of AIDS cases. The confidentiality of all reportable information is safeguarded by State law. State reporting requirements specify who must report HIV/AIDS data (e.g., doctors, laboratories), when reports are to be made, and in what form (e.g., by name, code, or demographic information).

State laws often require that clients be offered the option of confidential or anonymous testing and have the benefits of each explained.

State requirements vary on reporting of HIV infection; some States require reporting by name, and others only require reporting of demographic information or codes on HIV-infected individuals. States require reporting of diagnosed AIDS cases according to the Federal definition of AIDS. Under the new Federal definition of AIDS adopted December 18, 1992, which is based upon a CD4 cell count below 200 and the presence of selected opportunistic infections, many persons who would have previously been diagnosed as having HIV infection are now diagnosed as having AIDS.

Exhibit 7-2 Complying With Mandatory State HIV/AIDS

(more...)

Exhibit 7-2 reviews procedures that AOD abuse treatment programs should follow in complying with State reporting requirements as well as Federal regulations on disclosure of patient AOD information.

State requirements vary on reporting of HIV infection; some States require reporting by name while others only require reporting of demographic information or codes on HIV-infected individuals.

Recordkeeping

Both Federal and State provisions govern recordkeeping requirements for AOD abuse treatment programs that treat clients with HIV/AIDS, including the circumstances under which HIV/AIDS-related information can be released if it is part of an AOD file. AOD programs should consult counsel to determine what applicable State laws apply.

Federal AOD regulations require that written patient records be maintained in a secure room, locked file cabinet, or another safe and secure location and container. These regulations apply to client information generally; they do not specify HIV/AIDS status as protected information. However, such information is protected to the extent that it is included in the client's record at the AOD abuse treatment program, and release of such information would reveal that the individual was an AOD program client. Written procedures should be developed regulating access to and use of records.

State law governs the circumstances under which HIV/AIDS-related information must be recorded, where it must be recorded, and how it must be safeguarded. If a client signs a consent form permitting disclosure of information about AOD abuse and the client's file also contains information about HIV/AIDS, the program may not release information about HIV/AIDS unless it has complied with State law. For example, if a client's file contains both AOD and HIV/AIDS information and the client wants disclosure of AOD information to an outside agency but not HIV/AIDS information, there are several ways a program can proceed:

1. The consent form can be drafted in a way that includes all (or relevant parts of) the AOD information but excludes all HIV/AIDS information. The consent form must contain a statement of the purpose of the disclosure and how much and what kind of information will be disclosed. The

program can restrict access to HIV/AIDS information in a client's file by having the client sign a consent form that has as its purpose, for example, "referral for inpatient AOD treatment." How much and what kind of information to be disclosed would then be "AOD screening and assessment results."

2. The program can maintain a filing system that isolates drug and HIV/AIDS-related information in two different "treatment" and "medical" files and disclose only information from the "treatment" file. (This solution can be used whether or not State law protects HIV/AIDS information.)
3. The program can send the client's file without the HIV/AIDS-related information to the outside agency and put the following notice on the disclosure: *This file does not contain any information protected by section [fill in section number] of [State] law. The fact that this notice accompanies these records is NOT an indication that this client's file contains any information protected by section [fill in section number].* If the client wants HIV/AIDS information to be disclosed to an outside agency, the program must ensure that it is complying with State law requirements before it releases any such information.

Programs that receive funds from the CDC to conduct HIV counseling and testing must follow CDC HIV counseling and testing guidelines, which include provisions on the maintenance of HIV counseling and testing data. AOD abuse treatment programs should consult CDC or their State health departments regarding these CDC guidelines.

Maintenance of Records

Confidentiality of records may be maintained in several ways. State laws dictate how information is to be kept. Options include the following:

- *Single record.* Maintain a single, comprehensive client record that includes medical and HIV/AIDS information; limit access to medical staff and

others authorized to know medical information about the client. Reasons to include HIV/AIDS information in a client's file are for use in monitoring client progress, conducting case management, and maintaining agency compliance with program requirements on serving individuals. This approach, by making HIV/AIDS information available to a broader range of staff, requires the program to monitor more staff to ensure compliance with HIV/AIDS confidentiality requirements.

- *Separation of HIV/AIDS information.* Maintain HIV/AIDS information separately from the rest of the client's medical record; limit access to HIV/AIDS information to medical staff and other authorized personnel. This approach is useful in limiting HIV/AIDS information to a smaller number of program staff. However, the medical files should contain a reference marker which states that HIV/AIDS information is contained in a separate file; this is necessary so that staff will know where to locate this information.
- *Separation of all medical information.* Maintain all medical information separately from the rest of the client's record; limit access to medical personnel and other authorized personnel.

As with all other client data, HIV/AIDS information must be maintained in a safe and secure location accessible only to personnel directly involved in the provision of services to the client. It must, therefore, be inaccessible to staff members and others who have no need to know clients' HIV/AIDS status.

Criteria for the secure maintenance of HIV/AIDS client data are specified by State law and typically cover three areas:

- Record retention and destruction
- Secure physical storage of records
- Access to records by staff and others, including legal authorities.

Many States specify sanctions for breach of confidentiality. AOD treatment providers should consult counsel to determine these sanctions. Providers should establish State sanctions or, if none exist, implement their own sanctions, including disciplinary action for breaches of confidentiality. All staff should know the consequences of violating these principles.

Partner Notification

Persons who participate in sex or needle-sharing with HIV-infected individuals may be unaware that they are at risk for HIV infection. Partner notification procedures, also known as "contact tracing," exist to give these individuals the opportunity to receive an HIV test and appropriate counseling and medical treatment if they are found to be HIV positive. Partner notification also represents an opportunity to educate persons who may be at risk of HIV infection about behavioral risks and risk reduction.

According to CDC HIV counseling and testing guidelines, HIV testing programs should emphasize to infected clients that they have a responsibility to see that partners are informed of their status and referred for HIV counseling and testing. State laws on HIV counseling and testing may also recommend or require that HIV counseling include this type of counseling.

Many States require that State and local health department authorities routinely offer partner notification services to clients. AOD treatment providers may request that State or local health departments assist them in carrying out partner notification efforts with AOD abuse clients.

Many States require that State and local health department authorities routinely offer partner notification services to clients. AOD treatment providers may request that State or local health departments assist them in carrying out partner notification efforts with AOD abuse clients.

The two methods of partner notification are *patient referral and provider referral*. Patient referral occurs when the client, without the direct involvement of healthcare providers, tells partners that they may have been exposed to HIV and encourages them to seek HIV counseling and testing. Provider referral takes place when a client does not wish to notify partners directly and requests the assistance of a provider, typically the health department, in contacting them. The provider

then notifies the client's partners that they may have been exposed to HIV. This approach relies upon the client's supplying partners' names to the provider.

Partner notification begins with a discussion between the infected client (the index patient) and a trained counselor. This discussion should cover the patient's risk factors, the disease process and complications, and the need to notify partners who may be at risk of infection.

Disclosure of partner names by an index patient is a voluntary process, according to State law. Clients must receive counseling, testing, and referral services without regard to their willingness to disclose partners' names. Partners who are notified should never be told the identity of the client who supplied their names or given any information about the client's HIV/AIDS status.

Disclosure of HIV/AIDS-Related Information

In the wake of the AIDS epidemic, many States have passed laws protecting HIV/AIDS information about clients. These laws are designed to encourage populations at risk for HIV/AIDS to determine their HIV status, begin medical treatment early, and change risk behaviors. Many State laws were based on the concern that those who are seropositive will not receive healthcare and risk reduction education because of discrimination in employment, medical care, insurance, housing, and other areas if their status becomes known to others.

State laws protecting HIV/AIDS information vary in scope. Most permit disclosures with written client consent. Many States permit disclosures in specific circumstances without client consent (see Confidentiality Laws, above). Many States require that HIV/AIDS-related information be kept in particular kinds of files, be accessible only to certain program staff, and be protected from unauthorized disclosure. Because State laws vary, it is essential that programs consult local counsel to find out what their State HIV/AIDS laws require.

Duty to Warn

In a duty-to-warn situation, it is the legal and moral duty of a professional to report a client's threat to harm himself/herself or others. A program may also be confronted with a situation

where it wants to warn someone of a risk of HIV infection even if law does not impose such a duty. Many professionals feel that they have an ethical, professional, or moral obligation to prevent harm from occurring when they are in a position to do so.

A legal basis for duty to warn may be provided by State law or State court interpretation. There are no such provisions in Federal law or regulations. State laws typically allow, but do not require, a warning to be given. Most common are statutes that allow disclosure of AIDS-related information to spouses. Some State statutes also permit a health professional to undertake a risk-benefit assessment and to issue a warning if it is warranted and reasonable. Sometimes, these State laws prohibit disclosure of the infected person's identity, while allowing the healthcare provider to tell the person at risk that he or she may have been exposed.

A duty-to-warn situation might involve treatment staff awareness that an HIV-infected patient has failed to inform a sexual partner of his or her status. As a result, the partner is at risk for infection or may already have undiagnosed HIV infection. To avoid such situations, an AOD program should consider implementing an education program for clients' significant others, in which partners are informed that a high rate of HIV infection exists among AOD users and that they may wish to take precautions in sexual activity and injection drug use because of the possibility that their partners are HIV-infected.

A duty-to-warn situation might involve treatment staff awareness that an HIV-infected patient has failed to inform a sexual partner of his or her status. As a result, the partner is at risk for infection or may already have undiagnosed HIV infection.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the Univ. of Cal.* (17 Cal. 3d 425 (1976)). In that case, the California Supreme Court held a psychologist was liable for money damages because he failed to warn a potential victim whom the psychologist's patient had threatened to kill; the patient subsequently did kill the threatened individual. The court ruled that if a psychologist knows that a patient poses a serious risk of

violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances."

Courts in other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a client. Most of these cases are limited to situations in which clients threaten a specific identifiable victim, and they do not usually apply where a client makes a general threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to such situations.

In a duty-to-warn situation involving an AOD client, at least two and sometimes three questions must be answered:

- Is there a legal duty to warn in this particular situation under State law? Legal counsel should be consulted to answer this question.
- Even if there is no State legal requirement to warn an intended victim, does the program or counselor feel a moral obligation to warn him or her? It is advisable to seek legal counsel to answer this question.
- If the answer to either of the previous questions is yes, can the program warn the victim or someone likely to be able to take action without violating Federal AOD regulations?

The Federal AOD confidentiality requirements conflict with the "duty to warn" imposed by States that have adopted the principles of *Tarasoff*. Simply put, Federal confidentiality laws and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require. Moreover, Federal AOD regulations make it clear that Federal law overrides any State law that conflicts with Federal regulations (§2.20). In the only case, as of this writing, that addresses this conflict (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

There are four ways a program can proceed when a client makes a threat to harm himself/herself or another:

1. The program can make a disclosure pursuant to a court order if the court order is obtained after following the requirements of the Federal AOD regulations.
2. The program can make a disclosure that does not identify the individual who threatens to commit the harm as a patient. This disclosure can be made by making an anonymous report or, for a program that is part of a larger non-AOD entity, by making the report in the larger entity's name.
3. The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical intervention (§2.51).
4. The program can obtain the client's consent, although consent is unlikely to be given unless the client is suicidal.

Federal statutes and regulations prohibit any investigation or prosecution of a client based on information obtained from records unless the court order exception is used (42 U.S.C. §§290 dd-3(c) and ee-3(c) and 42 C.F.R. §2.12(d)(1)).

If none of the options mentioned above is practical, a program that believes there is a clear and imminent danger to a client or another person is probably wiser to report the danger to authorities or the threatened individual. This action is particularly the case for States that follow the *Tarasoff* rule. It is doubtful that any prosecution (or successful lawsuit) under the confidentiality regulations would be brought against a program or counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is carried out. In any event, the program should try to make the warning in a manner that does not identify the individual as an AOD abuser.

HIV Counseling and Tuberculosis Testing

Exhibit 7-3 Federal Law on Provision of Tuberculosis

(more...)

Federally funded AOD abuse treatment programs are required to provide counseling and education about HIV and tuberculosis (TB) as part of the "interim services" for individuals awaiting treatment for intravenous drug abuse (45 C.F.R. §96.126). In addition, such programs are required to provide TB services (See Figure 7-3), including development of protocols to prevent the transmission of tuberculosis, such as screening patients (45 C.F.R. §§96.127, 96.128). Many States also require these services. In addition, Federal regulations for methadone maintenance programs require HIV counseling of clients (21 C.F.R. §291 291.505(i)(c)) and also require TB testing as part of each client's initial medical evaluation (21 C.F.R. §291.505(d)(3)).

AOD abuse, HIV infection, and TB are highly correlated. AOD programs funded under the Federal Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule are required to provide TB services to clients or to make such services available. These services include TB testing, reporting of active TB cases to the health department, and providing treatment for those with active TB and preventive therapy for those with nonactive TB who require it. AOD abuse treatment programs must either provide these services themselves or make arrangements for their provision by healthcare providers who can and will serve the programs' clients. The steps programs must take to "make available" TB services is generally a matter of public health law.

TB Testing and Reporting Requirements

Generally, all persons entering AOD treatment programs should receive a TB skin test. Federally funded methadone maintenance treatment programs are required to include a tuberculin skin test as part of each client's initial medical evaluation. AOD programs can make admission and continued enrollment in treatment contingent upon a client's willingness to be tested. This rule is

different from that for HIV testing, discussed previously. Programs may not make HIV testing a mandatory requirement for admission to AOD treatment because HIV is not transmitted through casual contact and an HIV-positive client poses no danger to staff or other clients. AOD programs can deny treatment to anyone refusing TB testing because TB can be transmitted through casual contact and a client with active, untreated TB can pose a danger to staff and other clients.

Reporting of active TB is required in all States. State laws govern who must make a report. Generally, AOD programs that refer clients to outside healthcare facilities or laboratories for TB testing should make arrangements to ensure that those outside entities make the required reports.

AOD programs can deny treatment to anyone refusing TB testing because, unlike HIV, TB can be transmitted through casual contact and a client with active, untreated TB can pose a danger to staff and other clients.

AOD programs that provide TB testing services onsite must report active TB cases to the local and/or State health department, depending on State law. State reporting laws generally require that the client's name be disclosed. However, AOD abuse treatment programs making such reports must comply with Federal confidentiality regulations. Programs cannot simply send a list of names of active TB clients to the health department on program letterhead. There are a number of ways programs can report TB results to a health department without violating the Federal confidentiality regulations:

1. *Client consent.* The easiest way to comply with Federal regulations is to have all clients sign a consent form at the time they are tested for TB, permitting the reporting of positive test results to the health department.
2. *Nonidentifying reporting*. Programs that are part of a larger healthcare facility such as a general hospital can make the reports in the name of the larger entity without linking the client's name with AOD abuse treatment.
3. *Qualified service organization agreement*. A program can enter into a QSOA with a laboratory or healthcare facility that conducts TB testing or

other services for the program. The treatment program can then give the names of the clients with positive TB test results to the laboratory or healthcare facility, which can then report those names to the health department. In making the report, the laboratory or healthcare provider would not disclose that the clients were in AOD treatment.

4. *Court order.* In the unlikely event that the client refuses to consent and no other arrangements can be made to make a report to the health department, the program could apply for a court order to authorize it to disclose the client's name when it makes the report.

Providing Preventive Therapy and Treatment for Active TB

AOD abuse treatment programs have the option of providing TB treatment services themselves or making arrangements with healthcare providers to treat the clients. Programs may find that simply handing clients a card with the name and address of the healthcare provider offering TB services is not enough. It is wiser for programs to act as case managers for clients in need of TB services, arranging appointments and communicating with the healthcare provider to ensure that clients receive or continue to receive the services they need. To communicate with a healthcare provider about the TB services a client needs, the program will need the client's written consent authorizing ongoing communications between the AOD treatment program and the healthcare provider.

AOD treatment programs should maintain communication with the healthcare providers serving their clients because it is important for programs to know whether clients having active TB or receiving prophylaxis for latent MDR-TB are following through with treatment. Those who do not follow through can pose a hazard for staff and other clients; they should be barred from entering the treatment program if it is suspected that they are contagious.

Noncompliant Clients with TB

If a client with active TB or MDR-TB refuses to take his or her medication or stops taking it, the AOD program has a legal duty to report this behavior to the health department or another party as governed by State law. Programs should educate themselves about the legal requirements in their State. If the AOD program has referred the client to an outside provider, the outside provider will make the required report. If the AOD program is providing TB treatment services itself, it must make the report. Reports of noncompliance with TB treatment must follow Federal confidentiality regulations. The most efficient way to comply is with the client's consent. The most sensible time to obtain that consent is when the client begins TB treatment. The consent form should permit communication with the health department for as long as the course of treatment is expected to take place.

Duty to Warn

TB, unlike HIV, is contagious through casual contact. Responsibility for warning those at risk because of a client's active TB (for example, family members, significant others, or roommates) generally lies with the State or local health department. A major reason

active TB cases are reported to the health department is to facilitate contact tracing. AOD abuse treatment staff should educate themselves with the contact-tracing services of the local or State health department.

Footnotes

1

. This chapter was written for the consensus panel by Alan Gambrell and Margaret K. Brooks, Esq.

2

. For an explanation about how to deal with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations,* published in 1991 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.

. If the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).

TIP 15: Appendix A -- Bibliography

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TIP 15: Appendix B—Summary of Block Grants: Interim Final Rule (1993)

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Brief Summary of the Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule

§96.121

Terms used in the regulation are defined.

§96.122, §96.123

Applicants must submit an application each fiscal year which contains the assurances, the report and the State Plan as prescribed by the regulations. Beginning Fiscal Year 1994, applicants are required to use a standard application form prescribed by DHHS and approved by OMB under the Paperwork Reduction Act.

§96.124

Not less than 35 percent of the State's block grant is to be expended for prevention and treatment activities relating to alcohol and not less than 35 percent for prevention and treatment activities relating to other drugs. The States are to expend not less than 20 percent of the block grant on primary prevention activities. For Fiscal Years 1993 and 1994, the States are to expend not less than 5 percent of the block grant to increase (relative to the prior fiscal year) the availability of treatment services designed for pregnant women and women with dependent children, unless the Secretary waives the requirement in well-defined circumstances. For subsequent fiscal years, States must expend for such services not less than an amount equal to that expended in 1994. DHHS has set minimum services for which the block grant funds are to be expended on such women, including medical treatment for women, primary pediatric care for

their children, gender-specific substance abuse treatment, and sufficient transportation to ensure access by women to these services. See 45 C.F.R. §96.124(e).

§96.125 - Prevention

§96.126

States are to ensure that a program that treats IV substance abusers and receives funding under the grant notifies the State when it has reached 90 percent of its capacity. The States are to establish a capacity management program that reasonably implements such notification. In addition, the States are to ensure that each individual who requests and is in need of treatment for IV drug abuse is admitted either no later than 14 days from the request, or 120 days after such request if no program has the capacity to admit the person and if interim services are made available to the person not later than 48 hours after the request. Interim services include counseling on HIV, TB, and risks of needle sharing, and referral for HIV or TB treatment, if necessary. States are to require funded programs to establish a waiting list and such programs are to consult the capacity management system to ensure that such persons are admitted as early as possible. Such programs are also to conduct outreach programs.

§96.127

States are to ensure that entities that receive block grant funds routinely make available TB services (including counseling, testing, and referral for treatment, if necessary) to individuals requesting or receiving treatment for drug abuse. The State is to maintain statewide expenditures of non-Federal amounts at a level that is not less than an average level of such expenditures maintained by the State for the 2-year period preceding the first fiscal year for which the State receives such a grant.

§96.128

States whose rate of cases of AIDS is 10 or more per 100,000 individuals must carry out one or more projects to make available to the individuals early intervention services for HIV (including,

among other things, counseling and testing for HIV and, if positive, testing to determine the extent of immune deficiency). As discussed above, the State is to maintain State funding for such services just as it is to maintain funding for TB services. The amount to be expended from the block grant for HIV services varies among States and is set out in §1924 of PHS Act.

§96.129

The State must establish a revolving fund to make loans for the costs of establishing group homes for recovering substance abusers. This requirement is similar to that under the ADMS Block Grant, except that such group homes must house at least six, rather than four, individuals.

§96.130

Reserved for Tobacco

§96.131

The State is to ensure that each pregnant woman who seeks treatment is given preference in admissions and that when a treatment provider has insufficient capacity, the provider notifies the State. The State must then refer the woman to a program with capacity or, if no facility has capacity, make available interim services including prenatal care within 48 hours of her request. The State will also publicize that substance abuse treatment is available to pregnant women.

§96.132

Other requirements include (1) States must improve their referral process; (2) States are to ensure that entities that are involved in treatment and prevention activities and that receive funding under the grant provide continuing education in such services to their employees; (3) States are to coordinate prevention and treatment activities with other appropriate services, such as criminal justice, health services, etc.; and (4) States must have in effect a system to prevent inappropriate disclosure of patient records maintained by the State in connection with an activity funded under the program.

§96.133

The State is required to submit to the Secretary an assessment of need in the State for authorized activities, both by locality and by the State in general, including data showing the incidence and prevalence in the State of drug abuse, as well as alcohol abuse and alcoholism. The State (at least for Fiscal Years 1993 through 1996) is to submit its best available data on the incidence and prevalence of abuse, as well as a summary describing the weaknesses and biases in the data and a description on how the State plans to improve the sufficiency of data collected in the future. Comment was solicited on a more stringent requirement.

§96.134

The principal agency is to maintain aggregate State expenditures at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for a grant. The regulations also require that the block grant not be used to supplant State funding of alcohol and other drug prevention and treatment programs.

§96.135

The State is required not to expend block grant funds on a number of activities, including inpatient hospital services, except in the limited circumstances that are described in the regulations. Many of the same restrictions were imposed under the ADMS Block Grant Program.

§96.136

The State is required to provide independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State. At least 5 percent of the funded entities providing services in the State are to be reviewed annually. The programs reviewed are to be representative of the total population of funded programs.

§96.137

Block grant funds are the "payer of last resort" for the women's set-aside (§96.124(c)), tuberculosis services (§96.127), and Early Intervention Services for HIV.

(§96.128).

Programs that receive funds for these purposes are to make every reasonable effort to collect reimbursement for the cost of providing such services.

TIP 15: Appendix B—Summary of Block Grants: Interim Final Rule (1993)

Brief Summary of the Substance Abuse Prevention and Treatment Block Grants: Interim Final Rule

§96.121

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Reserved for Tobacco

§96.131

The State is to ensure that each pregnant woman who seeks treatment is given preference in admissions and that when a treatment provider has insufficient capacity, the provider notifies the State. The State must then refer the woman to a program with capacity or, if no facility has capacity, make available interim services including prenatal care within 48 hours of her request. The State will also publicize that substance abuse treatment is available to pregnant women.

§96.132

Other requirements include (1) States must improve their referral process; (2) States are to ensure that entities that are involved in treatment and prevention activities and that receive funding under the grant provide continuing education in such services to their employees; (3) States are to coordinate prevention and treatment activities with other appropriate services, such as criminal justice, health services, etc.; and (4) States must have in effect a system to prevent inappropriate disclosure of patient records maintained by the State in connection with an activity funded under the program.

§96.133

The State is required to submit to the Secretary an assessment of need in the State for authorized activities, both by locality and by the State in general, including data showing the incidence and prevalence in the State of drug abuse, as well as alcohol abuse and alcoholism. The State (at least for Fiscal Years 1993 through 1996) is to submit its best available data on the incidence and prevalence of abuse, as well as a summary describing the weaknesses and biases in the data and a description on how the State plans to improve the sufficiency of data collected in the future. Comment was solicited on a more stringent requirement.

§96.134

The principal agency is to maintain aggregate State expenditures at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for a grant. The regulations also require that the block grant not be used to supplant State funding of alcohol and other drug prevention and treatment programs.

§96.135

The State is required not to expend block grant funds on a number of activities, including inpatient hospital services, except in the limited circumstances that are described in the regulations. Many of the same restrictions were imposed under the ADMS Block Grant Program.

§96.136

The State is required to provide independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State. At least 5 percent of the funded entities providing services in the State are to be reviewed annually. The programs reviewed are to be representative of the total population of funded programs.

§96.137

Block grant funds are the "payer of last resort" for the women's set-aside (§96.124(c)), tuberculosis services (§96.127), and Early Intervention Services for HIV.

(§96.128).

Programs that receive funds for these purposes are to make every reasonable effort to collect reimbursement for the cost of providing such services.

TIP 15: Appendix C—Elements of a Needle Exchange Program

Information in this appendix is from two sources. The first section briefly describes a report published in 1993 on the public health impact of needle exchange programs (NEPs) in the United States and abroad. Information on ordering the report is provided. The second section presents material from a 1993 proposal to develop the San Francisco Needle Exchange Program. The proposal describes a three-phase program for implementing street-based outreach activities targeted to injection drug users who are not in treatment and those in treatment who are experiencing relapse.

The Public Health Impact of Needle Exchange Programs

A needle exchange program (NEP) has been defined as "a facility where drug injectors can obtain sterile needles and syringes and return used injecting equipment" (Donoghoe et al., 1992). NEPs seek to reduce the harm associated with injection drug use and particularly with the sharing of injection equipment, acknowledging that many injection drug users (IDUs) continue to engage in these practices. Proponents of NEPs have argued that they could decrease the transmission of HIV by increasing the probability that IDUs use uninfected syringes, produce reductions in HIV risk behaviors, and refer IDUs to drug treatment or other public health services. Opponents have countered that NEPs condone drug use and increase drug use in the community.

In 1992, the U.S. Centers for Disease Control and Prevention sponsored an evaluation of the public health impact of NEPs in the United States and abroad. The evaluation was carried out by a multidisciplinary team of investigators at the University of California, Berkeley, and the University of California, San Francisco. The research team submitted its final two-volume report in October 1993 (Lurie et al., 1993). The following is a summary of the report's conclusions.

As of September 1, 1993, there were at least 37 NEPs operating in 30 U.S. cities. U.S. NEPs distributed more than 2.4 million syringes in 1992. All U.S. NEPs also provide condoms to clients and most distribute bleach for syringe infection, as well as health pamphlets and alcohol wipes. Most U.S. NEPs selectively refer clients for drug treatment. At least 794 NEP clients have entered drug treatment in five cities.

The median annual budget of U.S. and Canadian NEPs studied was $169,000, a sum that would support about 60 methadone maintenance slots for a year. NEPs generally reach IDUs with long histories of injection drug use who remain at significant risk for HIV infection. While some NEPs appear to have reached large proportions of the local IDU population at least once, others are reaching only a small fraction of local IDUs.

Although quantitative data are difficult to obtain, those available provide no evidence that NEPs increase the amount of drug use by NEP clients or change overall community levels of drug use. NEPs in the United States have not been shown to increase the total number of discarded syringes and can be expected to result in fewer discarded syringes. The majority of studies of

NEP clients demonstrate decreased rates of HIV drug risk behavior, but not decreased rates of HIV sex risk behavior.

Studies of the effects of NEPs on injection-related infectious diseases other than HIV provide limited evidence that NEPs are associated with reductions in subcutaneous abscesses and hepatitis B among IDUs. Studies of the effect of NEPs on HIV infection rates do not and probably cannot provide clear evidence that NEPs decrease HIV infection rates, due in part to the need for large sample sizes and the multiple impediments to randomization. However, NEPs do not appear to be associated with increased rates of HIV infection. Mathematical models suggest that NEPs can prevent a significant number of infections among clients, clients' drug and sex partners, and clients' children. In almost all cases, the cost per HIV infection averted is far below the $119,000 lifetime cost of treating an HIV-infected person.[1]

The San Francisco Needle Exchange Program

1. Needle Exchange Program as Part Of a Comprehensive Plan

The plan for a needle exchange program in San Francisco is contingent upon the need for an expanded vision, which would include treatment availability as well as the exchange of needles. Increased access to drug treatment programs is the foundation of a fully effective program to break the link between HIV infection and drug use. A number of recent awards have increased the capacity for substance abuse treatment for IDUs (CARE, Waiting List Reduction Grant, Waiting Period Reduction Grant, Critical Population Grant, and others). Although the number of drug treatment programs and treatment slots have been enhanced in recent years, waiting lists still exist and surveys still show many IDUs that are not enrolled in any type of treatment. Moreover, recent behavioral surveys indicate widespread use of illicit drugs and alcohol use that continues to be correlated with the spread of other sexually transmitted diseases.

2. Current Legislation Re: Needle Exchange

Currently, the Business and Professions Code, Article 5.5 Hypodermics, section 4140, states, "No person shall furnish hypodermic needles or syringes, by sale or otherwise, without a permit issued by the board, except as otherwise provided by this article."

Health and Safety Code, section 11014.5, defines drug paraphernalia and section 11364.7 makes it a misdemeanor for any person ". . . to possess with intent to deliver, furnish or transfer . . . drug paraphernalia . . . used to inject the human body with a controlled substance."

3. Suggested Needle Exchange Program Design

Phase I

Numerous exchange sites will be available. Street-based outreach workers will exchange needles and related paraphernalia. Street-based outreach services are the first priority and most effective way to implement a needle exchange program. Outreach workers will not work in isolation but will consist of teams. Phase I can be implemented immediately.

Phase II

A "storefront" or stationary site will be utilized to distribute needles and related materials. The stationary site will also be utilized for support groups; referrals; and medical, substance abuse, or psychiatric interventions. The stationary site offers more privacy than street outreach efforts, and some clients may prefer the storefront site for referrals, counseling, interventions, etc. The stationary site will also be utilized to store the items and host community meetings and client activities. The stationary site will not be housed in a substance abuse treatment program. Phase II can be implemented within 3 to 4 months after approval of the program.

Phase III

A van will be utilized for the NEP. The van will work in conjunction with the storefront and the street outreach efforts and will be used to provide all services of the needle exchange program. The van can also accommodate special requests (for instance, a rock concert). The van will

provide backup to the outreach teams, can be utilized for emergencies (i.e., driving a client to a hospital), and will target high-risk neighborhoods. Phase III can be implemented within 4 months after approval of the program.

Community preference, values, and acceptance will be considered before the assignment of Phase I, Phase II, or Phase III activities. A variety of strategies will be used to announce the schedules of the team or van (i.e., cards, 24-hour recording, and posters).

Outreach Activities: Multidisciplinary Roving Teams

Outreach will be conducted by interdisciplinary teams that will include individuals trained in areas such as substance abuse, HIV disease, community referrals, HIV testing, primary healthcare, and crisis intervention. Teams will include at least three workers, and they will concentrate their efforts in areas populated by IDUs such as the Tenderloin, the Western Addition, Bayview Hunter's Point, and the Mission. The teams will have a regular roving schedule that will be communicated by brochures, posters, word-of-mouth, and linkages with community-based organizations in high-risk areas. Determination of the initial target areas will be based on substance abuse data, community support, and the latest seroprevalence information.

It is anticipated that the San Francisco Needle Exchange Program will be able to attract clients in substantial numbers and will reach individuals often unreached by other services. Special outreach strategies will be developed to attract women, gays, young injectors, new injectors, racial/ethnic minorities, and other high-risk groups.

Needle/Syringe Exchange

Coded needles will be provided to addicts on a one-for-one exchange basis. In addition, other items will be provided such as cotton balls, bandages, antiseptic solutions, etc. New, sterile needles and syringes will be provided. Syringes and needles will be provided in a puncture-proof container. An I.D. marker system may be developed.

Range of Service

The team will be skilled in the areas of substance abuse assessment and referral. The encounter may be brief until a trusting relationship has been established. Some encounters may last just minutes; others may last 45 minutes or more, depending upon the receptivity and needs of the client. The NEP is part of a comprehensive program to reduce HIV infection among IDUs in San Francisco. While the needle exchange program has the simple, straightforward mission to distribute clean needles and supplies to IDUs, the encounter is a unique opportunity to serve as a bridge to alcohol and drug treatment, primary healthcare, TB/STD services, mental healthcare, HIV programs, and other community services. Services will be provided free of charge.

Other Items Distributed

Other items may be distributed, such as condoms, dental dams, safe-sex products, AIDS education material, resource information, coupons indicating priority status for alcohol and drug treatment, safe-sex guidelines, bleach, sterile water, clean cotton and needle use, and harm reduction and needle hygiene information.

Locations

The San Francisco Needle Exchange Task Force suggested eleven possible locations—the Tenderloin, the Mission, Bayview Hunter's Point, the Western Addition, Polk, Haight, Outer Mission, South of Market/6th Street, South of Market/Ballpark, Visitation Valley, and Oceanview.

Prevention Point currently targets the Tenderloin, the Mission, Civic Center, and South of Market.

At the point of implementation, the target sites will be selected based upon the most recent information regarding high-risk neighborhoods, community input, and coordination with Prevention Point.

Target Population

The target populations are IDUs not in treatment, IDUs on waiting lists for treatment, and IDUs experiencing relapse (may be currently enrolled in treatment). Specialized outreach, recruitment,

referral, and supportive services will be provided to IDUs who are young injectors, racial/ethnic minorities, new injectors, women, and the homeless.

Participant Eligibility

Services will be provided to IDUs. The IDUs will need a needle to exchange. Needles will be exchanged on a one-for-one basis. The participants may be offered other services such as referral. However, they will not be required to participate in other services in order to receive needles.

Participation in research (if applicable) or evaluation activities will be voluntary.

A Bridge to Treatment

It is anticipated that the NEP will become a bridge to substance abuse treatment for a number of addicts. The interactions between staff of the San Francisco NEP and the clients will often result in referrals to alcohol and drug abuse treatment, HIV counseling and testing, and primary care sites. Early intervention for HIV through counseling and testing programs and alcohol and drug abuse treatment programs is the most effective way to reduce the potential for infection (or the spread of infection). The intervention of the NEP involves elements of reducing HIV transmission by decreasing the number of injections that involve contaminated equipment and actively linking drug injectors to HIV and drug treatment services.

Accessing the publicly funded alcohol and drug treatment system can be confusing. Available slots change on a day-to-day basis. The team will work closely with the staff of Community Substance Abuse Services (CSAS) in terms of referrals, placement, priority admissions, and identification of available slots. Clients will receive coupons that indicate a priority status in the publicly funded substance abuse system. Clients who do not wish treatment may continue to receive needles. An additional attempt to recruit them into treatment may occur at a later date. Because addiction is a chronic relapsing disorder, there will be no limit as to the number of times an individual may utilize the program.

The team will also work with the network of HIV and primary care providers. They will triage and assess the needs of the client and provide an effective link to the appropriate level of care, be it HIV anonymous or confidential testing or primary healthcare services.

Waiting Lists for Substance Abuse Treatment

Most of the programs in San Francisco have a waiting list for treatment. Because of the new management information system, CSAS will have the capability of identifying available slots in all modalities in any given week. CSAS will assign a staff person to the NEP and this assignment will help with referrals into substance abuse treatment and referrals between modalities (i.e., from outpatient to residential care). This person will assist prioritized clients entering substance abuse treatment (pregnant addicts, adolescents, IDUs, and HIV-infected individuals).

Referrals

Referrals will be provided to drug and alcohol programs, HIV testing sites, primary healthcare programs, STD clinics, youth programs, TB programs, etc. It is important that referral information be written in simple, easy-to-understand language. Incoming referrals will be accepted from multiple sources such as individual requests, community-based organizations, police, and treatment/prevention programs.

Unsuccessful Treatment Interventions

It is an anticipated outcome that some individuals, no matter how much outreach and intervention is directed toward then, will never enroll in a drug treatment program. In a New York City pilot program for needle exchange, 57 percent of people targeted entered a substance abuse treatment program. Because the rate of transmission of the HIV virus, especially within the IDU population, continues to increase exponentially, the fact that there will be unsuccessful interventions should not hinder the implementation of this program. Denial is always present in individuals with substance abuse problems and often complicates the referral and intervention process.

Special Populations

Young IDUs and new injectors. Because of their risk of HIV infection, young IDUs will be served by the program, as will be new injectors of any age. The teams will need specialized training and skills in regard to youth services in areas that are frequented by young IDUs, and specialized referrals will be provided to youth and young adult services.

Women. Women and pregnant women may be served by this program. Women need these services for the same reasons male IDUs need services. The perinatal transmission of the virus is a concern. The teams will include women and will cover the areas of San Francisco frequented by female IDUs. The teams will provide specialized interventions and referrals for women and pregnant women. Pregnant women are a priority admission in the publicly funded substance abuse treatment system.

Training will be provided for the outreach teams and will include information on AIDS prevention, needle hygiene, team building, safety precautions, stress management, and support options. This training will be extensive Racial/ethnic minorities. Outreach teams will be multicultural and sensitive to the needs of racial/ethnic IDUs. Specialized referrals will be provided that are respectful of cultural values.

Gay IDUs. Outreach will be provided to gay IDUs. The teams will provide services in areas requested by gay IDUs. Specialized referrals will be provided when an IDU prefers a gay-sensitive organization. The outreach teams will include individuals who are heterosexual, homosexual, or bisexual.

Homeless. Outreach will be provided to homeless IDUs. The teams will provide services in areas that are commonly utilized by the homeless. Outreach teams will be familiar with a range of referrals, including shelter, food, and entitlement programs.

Training of Staff

Training will be provided for the outreach teams and will include information on AIDS prevention, needle hygiene, team building, safety precautions, stress management, and support options. This training will be extensive before the delivery of service, then ongoing throughout the course of employment with the needle exchange effort. Team members will also receive training on referral options to primary medical care, legal services, HIV services, housing, drug and alcohol treatment, and social services. Topics will include AIDS education, HIV counseling and testing, and client advocacy with the drug treatment community. Specialized support groups will be provided for employees working on this project.

Disposal of Needles

Disposal of needles will be conducted consistently with the Department of Public Health (DPH) Body Substance Precautions Policy as it applies to the disposal of infectious waste. Workers will be provided with an orientation to this policy and will be provided with all the necessary equipment and resources in this regard.

Operational Issues

Employment issues/hazardous incidents. Employee safety is an important issue. A specialized training program will provide classes in teamwork building, emergency referrals, assessment of potential dangers, and drawing limits. Since recovering IDUs may be readily accepted by the out-of-treatment population, their involvement as employees in the program is suggested. Individuals should not work in isolation. The team may enter "shooting galleries," confront drug dealers, or confront individuals meeting the 51/50 criteria. Employee Assistance Services should be provided to employees and may be helpful in terms of relapse prevention, assessment, and referral for burnout and stress-related disorders. Nurses may be part of the multidisciplinary teams to assist with medical referrals. Protocols will be developed to deal with potential hazardous incidents such as a needle stick, violence, overdose, etc.

Record keeping. In order for this program to be utilized by IDUs, a degree of trust must be established. Information recorded will be number of contacts; client (case) demographics;

number of needles exchanged; number of items distributed, such as condoms; return rates; and referral information. Client confidentiality will be assured. A unique fictitious name code may be utilized to control needles issued and return of needles (i.e., was the needle returned by the same person to whom it was issued?).

Advertising. Innovative methods, such as word-of-mouth, coupons-for-treatment services, posters, handouts, handbills, tee-shirts, announcements at events, television/radio, etc., will be used to advertise the program. A telephone number will provide a recorded message with the location of the program and information on how to access the street outreach workers. Comic strips, bus ads, and cooperative ventures may also be helpful in advertising the service.

Evaluation

Needle exchange programs can potentially slow the spread of HIV through a reduction of needle-sharing behavior, injection drug use, or high-risk sexual behavior -- a reduction that can be attained through the provision of clean needles and health education to IDUs participating in a NEP. However, opponents of needle exchange maintain that the provision of clean needles removes at least one barrier to drug use and thus may actually promote that behavior.

Because of this controversy, it is important that a needle exchange program be submitted to a rigorous evaluation that attempts to answer the questions above. Behavioral surveys regarding the effectiveness of NEPs have accumulated over the past several years, with most studies showing that NEPs have led to a reduction of injection equipment sharing and served as bridges to treatment for many IDUs. However, critics have cited the methodological flaws in many of these studies and stood by their claims that no study has yet proven that NEPs reduce HIV infection.

In August 1991, Yale University announced the results of an innovative evaluation of the New Haven Needle Exchange Program in which a tracking system was devised to assess sharing behavior. Using a mathematical projection model, researchers concluded that the program

reduced new HIV infections by 33 percent. The findings led the National Commission on AIDS to endorse needle exchange programs as a component of an overall strategy.

Prevention Point in San Francisco has undergone considerable evaluation. The Prevention Point Research group has collaborated with investigators from the University of California at San Francisco (UCSF) Center for AIDS Prevention Studies as well as the Institute for Health Policy (see Prevention Point section). A street-based survey of needle exchange clients has been included in the Urban Health Study of out-of-treatment IDUs in San Francisco.

These studies have illustrated the following: 1) a strong association between frequent use of the syringe exchange and not sharing syringes; 2) no evidence for increased frequency of drug injection among current needle exchange users or recruitment of new drug users because of needle availability; 3) tendency for HIV-positive IDUs, as opposed to those who are HIV negative or who do not know their antibody status, to use a NEP; 4) great interest among IDUs using a NEP to be HIV tested onsite; and 5) strong evidence that the current NEP in San Francisco has become the principal source of clean needles for IDUs.

The San Francisco Department of Public Health (SFDPH) supports a continuing and comprehensive evaluation of San Francisco's NEP, especially in the following areas:

1. More concrete and valid measurements of its contribution in reducing HIV among IDUs
2. Effectiveness in referring IDUs to drug treatment
3. Effectiveness of providing IDUs with onsite HIV testing and health services.

It should be noted that the evaluation recommendations above are not intended to precede funding support for a NEP in San Francisco but rather to be implemented with the NEP simultaneously.

4. Oversight

The contract will be a collaborative venture between Community Substance Abuse Services and the AIDS office via a contract with the Department of Public Health.

The delivery of services will be conducted by a competitively selected community-based organization (CBO). Oversight of this pilot program will be provided by a Needle Exchange Committee that will advise both the SFDPH and the CBO. The committee could consist of representatives from the city government; local and State public health officials; treatment providers; public health professionals; recovering addicts; substance abuse provider groups; volunteers from Prevention Point; the San Francisco Police Department; researchers/evaluators; CBOs; the legal, religious, and scientific communities; women's groups; and others.

5. Public Support and Involvement

In a study done by the Public Research Institute of San Francisco State University in 1989, it was found that 70 percent (n=406) of San Francisco registered voters were supportive of the distribution of needles as a method of AIDS prevention. The question was put on the ballot in 1990 as Proposition O, and 62 percent of the voters responded "Yes" to the policy question:

- Shall it be the policy of the people of San Francisco to call upon the State Legislature to eliminate all criminal and civil penalties on the manufacture, use, sale or distribution of hypodermic needles?

This study, as well as ongoing inquiries to the various AIDS service providers in San Francisco, support the premise that the recruitment of volunteers and solicitation of donations would be an additional component to the program. Volunteers could not only work with the outreach and publicity for the project but could also be trained in the intervention techniques necessary to work with the clients of the program. Recovering addicts will work with the program. Additionally, donations will be accepted and utilized for equipment and educational materials. A speakers bureau may be established.

6.Legal Issues and Relationship With Law Enforcement

The San Francisco Needle Exchange Program will begin if legislation is changed to allow it. The law enforcement agencies will be members of the Advisory Committee in order to plan and monitor the implementation phase of the program.

Special protective carriers may be distributed to participants of the needle exchange program that will protect police from needle-stick injuries at the time of arrest.

Footnotes

Copies of the report The Public Health Impact of Needle Exchange Programs in the United States and Abroad (Vol. I - 500 pages, Vol. 2 - 300 pages) may be obtained from Peter Lurie, M.D., M.P.H., University of California, San Francisco, Prevention Sciences Group. Copies of the Report Summary (43 pages) may be obtained from CDC National AIDS Clearinghouse

Appendix D—Cultural Proficiency Questionnaire

The Cultural Proficiency Questionnaire is not available in electronic format. To obtain a copy of the questionnaire, order a hard copy of this TIP: Treatment for HIV-Infected Alcohol and Other Drug Abusers (15) by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or accessed at http://www.health.org/pubs/catalog/ordering.html. The reference number for this TIP is BKD163.

TIP 15: Appendix E - Information About the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (The CARE Act)[1]

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 represents the largest dollar investment made by the Federal Government to date specifically for the provision of services for people with human immunodeficiency virus (HIV) infection. The purpose of the act is "to improve the quality and availability of care for individuals and families with HIV disease."

The act directs assistance to:

- Metropolitan areas with the largest number of reported cases of acquired immunodeficiency syndrome (AIDS) to meet emergency service needs (Title I)
- All States to improve the quality, availability, and organization of healthcare and support services for individuals with HIV disease and their families (Title II)
- All States to support early intervention services (Title III)
- Support a series of specified general provisions including evaluations and reports, as well as research and services for pediatric patients (Title IV).
- The appropriations for Titles I, II, and III of the CARE Act were as follows:
- Fiscal Year 1991 $220.5 million
- Fiscal Year 1992 $279.3 million
- Fiscal Year 1993 $348.1 million
- Fiscal Year 1994 $579.4 million.

Title IV did not receive funding until Fiscal Year (FY) 1994. Total appropriations for Titles I, II, III, and IV in FY 94 was $658.1 million.

The Health Resources and Services Administration (HRSA) has lead responsibility for the CARE Act. Its Bureau of Health Resources Development (BHRD) manages Titles I and II, the Bureau of Primary Health Care (BPHC) is responsible for Title III(b), and the Maternal and Child Health Bureau (MCHB) is responsible for Title IV.

Title I: Emergency Relief Grants to Eligible Metropolitan Areas (EMAs)

Purpose: To provide emergency assistance to localities that are disproportionately affected by the HIV epidemic.

Eligible grantees: For FY 91, metropolitan areas reporting a total of more than 2,000 cases of AIDS to the Centers for Disease Control (CDC) by June 30, 1990, or in which the per capita incidence of cumulative cases of AIDS is not less than 0.0025. For subsequent fiscal year funding, the same criteria apply for total cases or incidence reported as of March 31 of the most recent fiscal year (i.e., for FY 94 funding, data reported as of March 1993).

As of December 1, 1994, 42 EMAs are eligible.

Administration: Grants are awarded to the Chief Elected Official (CEO) of the city or urban county that administers the public health agency providing outpatient and ambulatory services to the greatest number of people with AIDS in the area eligible for the grant.

There are two major administrative requirements:

1. The CEO must have an intergovernmental agreement with any area political subdivision that provides HIV-related health services and in which at least 10 percent of the EMA's AIDS cases were diagnosed. That agreement establishes an administrative mechanism to allocate funds and services.
2. The CEO must establish a new entity or designate an existing one to serve as an HIV Health Services Planning Council (HHSPC). The designated

entity should have experience in planning for the HIV healthcare needs within the EMA. The CARE Act requires that this entity or council establish priorities for HIV care delivery.

The HHSPC must include, at a minimum, representatives from 11 specific groups:

- Healthcare providers
- Community-based and AIDS service organizations
- Social services providers
- Mental healthcare providers
- Local public health agencies
- Hospital planning agencies or healthcare planning agencies
- Affected communities, including individuals with HIV disease
- Nonelected community leaders
- State government
- Entities receiving grants under Title II of the act (early intervention)
- The lead agency of any HRSA demonstration grant.
- The HHSPC must
- Establish priorities for allocating funds within the EMA
- Develop a comprehensive plan for the organization and delivery of HIV health services that is compatible with existing State or local plans
- Assess the efficiency of the administrative mechanisms to rapidly allocate funds to areas of greatest need.

Use of grants: The EMA must agree to distribute grant funds according to the priorities established by the HHSPC. Grant funds are to be used for delivering or enhancing HIV-related

- Outpatient and ambulatory health and support services, including case management and comprehensive treatment services
- Inpatient case management services that expedite discharge.

The EMA may make awards to public or nonprofit entities, including hospitals (including Veterans Affairs facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, and homeless health centers.

Title II: HIV Care Grants to the States

Purpose: To enable States to improve the quality, availability, and organization of healthcare and support services for individuals with HIV disease and their families.

Eligible grantees: Each State, the District of Columbia, Puerto Rico, and the territories are eligible for funds, based on the number of AIDS cases diagnosed and reported to CDC for the 2 most recent fiscal years, and the average per capita income of State/U.S. population. The minimum grant amount will be $100,000.00.

Use of grants:

- To establish and operate HIV care consortia designed to provide a comprehensive continuum of care to individuals with HIV disease and their families. States reporting 1 percent or more of the total number of AIDS cases reported nationally are required to use at least 50 percent of their CARE grant to create and operate consortia in those areas of the State with the largest number of individuals with HIV disease.
- To provide home and community-based care services for individuals with HIV disease.
- To provide assistance to ensure the continuity of health insurance coverage for persons with HIV disease.
- To provide treatments to prolong life or prevent serious deterioration of health to individuals with HIV disease.

In addition, the act requires that 15 percent of grant funds be set aside to provide health and support services to infants, children, women, and families with HIV disease.

HRSA may use up to 10 percent of the total funds appropriated for Title II to make competitive grant awards for Special Projects of National Significance (SPNS). SPNS programs are to assess innovative and replicable models of care and treatment for individuals with HIV.

HIV Care Consortia

Definition: An association of one or more public and one or more nonprofit private, healthcare, and support services providers, and community-based organizations. These must operate within areas determined by the State to be most affected by HIV disease. The association agrees to use grant assistance to plan, develop, and deliver (directly or through agreements with others) comprehensive outpatient health and support services for individuals with HIV disease. These services may include:

- Essential health services: case management; medical, nursing and dental care; diagnostics; monitoring and medical followup services; mental health, developmental, and rehabilitation services; and home health and hospice care
- Essential support services: transportation, attendant care, homemaker services, day or respite care, benefits (e.g., health, disability, etc.) advocacy, advocacy services provided through public and nonprofit private entities, nutrition services, housing referral services, child welfare and family services (including foster care and adoption services), and counseling on living with HIV.

States are to give priority in funding first to consortia receiving assistance from HRSA for adult/pediatric HIV-related care demonstration projects, then to any other existing HIV care consortia.

Home and Community-Based Care

Definition: With respect to an individual with HIV disease, skilled health services are furnished in the individual's home under a written plan of care established by a case management team. The plan includes appropriate healthcare professionals and the following services and items:

- Durable medical equipment
- Homemaker or home health aide services and personal care services provided in the home
- Day treatment or other partial hospitalization services
- Home intravenous and aerosolized drug therapy
- Routine diagnostic testing
- Appropriate mental health, developmental, and rehabilitation services.

Funds received may not be used for services in an inpatient hospital, nursing home, or other long-term care facilities.

States may make grant awards under this section of the law to entities providing outreach services to

- Help individuals with HIV disease (including rural residents)
- Coordinate home and community-based care with other HIV-related health services provided by public and private entities.

In making grant awards, States will give priority to entities participating in HIV care consortia and those that will use home and community-based funds for low-income individuals with HIV disease.

Health Insurance Coverage

States may use grant funds to establish a program of financial assistance for low-income individuals with HIV disease who meet eligibility criteria. The funds will allow these individuals to either maintain continuity of their existing health insurance coverage or to receive medical benefits under another health insurance program, including risk pools.

States may not use these funds to pay for creating or administering a liability risk pool or to pay any amount expended by the State under Medicaid.

Provision of Treatments

States may use funds under this section to establish a program to provide treatment for individuals eligible to participate, that is determined to prolong life or prevent the serious deterioration of health arising from HIV disease. Eligible individuals must have a medical diagnosis of HIV and be a low-income individual as defined by the State. The State shall determine which treatments are eligible to be included, in accordance with guidelines issued by the Secretary, Department of Health and Human Services (DHHS).

Matching funds: States with more than 1 percent of AIDS cases reported nationally in the previous 2 years must make available (either in cash or in-kind contributions -- including donations from public or private entities) resources to match Federal funds awarded under Title II. (The law specifically excludes Puerto Rico from this requirement.) This matching requirement is by formula as follows:

- 1991 - $1 State for every $5 Federal
- 1992 - $1 State for every $4 Federal
- 1993 - $1 State for every $3 Federal
- 1994 - $1 State for every $2 Federal
- 1995 - $1 State for every $2 Federal.

Special Projects of National Significance (SPNS)

(Title II of the CARE Act)

Purpose: SPNS programs are to contribute to the advancement of knowledge and skills in the delivery of health and support services to persons with HIV disease.

Eligible grantees: Any public or private nonprofit organization, including community-based organizations. Grants are usually awarded for 3-year cycles.

Use of grants: Up to 10 percent of Title II funds may be set aside for SPNS grants. SPNS programs must

- Evaluate the effectiveness of a program model
- Appraise the innovative qualities of a model's activities
- Determine the potential replicability of the model in other similar localities or nationally.

Each year the SPNS program examines the dilemmas confronting HIV service providers to determine what issues should be addressed through demonstration and evaluation projects. In 1991 and 1992, the first 2 years of funding, priority was given to projects that would

- Demonstrate improved access to care through reduction of social, financial, and transportation barriers experienced by one of these five special population groups with HIV: rural residents; women, children and/or adolescents; incarcerated persons; recently released inmates; and American Indians/Alaska Natives
- Demonstrate models of advocacy on behalf of persons infected with HIV that assure timely receipt of adequate health and support services
- Reduce social isolation of people with HIV in order to improve their quality of life
- Integrate mental health services into primary care sites.

In FY 93, a fifth priority was added that focused on the unique problems of identifying and caring for adolescents who were infected with or affected by HIV.

Title III(b): Early Intervention Services

Prevention: To support early intervention HIV services (EIS) for people with AIDS and HIV infection.

Eligible grantees: Organizations that are eligible to apply for Title III(b) funds include public or nonprofit private entities currently providing comprehensive primary care services to populations at risk for HIV infection, and the following other entities:

- Migrant health centers receiving support under sections 329 of the PHS Act
- Community Health Centers receiving support under sections 330 of the PHS Act
- Healthcare for the Homeless centers receiving support under sections 340 of the PHS Act
- Family Planning grantees (other than States) receiving support under section 1001 of the PHS Act
- Comprehensive Hemophilia Diagnostic and Treatment Centers
- Federally qualified health centers supported under section 1905(1)(2)(b) of the Social Security Act.

Use of grants: The early intervention program must provide a continuum of HIV services including

- HIV risk reduction counseling and testing
- Partner involvement strategies for HIV risk reduction
- Transmission prevention
- Counseling and education on living with HIV disease
- Appropriate medical evaluation and clinical care (such as CD4 monitoring; antirotroviral therapy; diagnosis, prophylaxis, and treatment of opportunistic infections, including TB; and malignancies)
- A plan for managing the coepidemics of tuberculosis and substance abuse
- Referrals.

The applicant may also provide optional services such as

- A program of outreach that will explain the benefits of early intervention to those who may have HIV disease or who may be at high risk for contracting the disease
- A program of outreach to providers to make them aware of the availability and benefits of EIS services
- A program providing assistance to individuals in establishing eligibility for financial assistance and services under Federal, State, or local programs that provide health services, mental health services, social services, or other appropriate services
- A program to provide case management to persons infected with HIV.

Title IV: General Provisions, Reports, and Evaluation

HIV Demonstration Program for Children, Adolescents, and Families

In FY 1994, Congress transferred the Pediatric/Family AIDS Demonstration Program to Title IV of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The program will be permanently authorized in Section 1071 of the Public Health Service Act. As a result of this transfer to Title IV, the focus of the program is further expanded to develop innovative models that link systems of comprehensive primary/community-based medical and social services for the affected population with National Institutes of Health (NIH) and other clinical research trials.

Other sections of this title were not funded in FY 1994, but a summary of some of the title's authorities is provided below.

Research, Evaluation, and Assessment Program

Purpose: The Agency for Health Care Policy and Research shall establish a grant program of independent research to develop

- A comparative assessment of the impact and cost- effectiveness of major models for organizing and delivering HIV-related healthcare, mental healthcare, early intervention, and support services that report on patient outcomes, satisfaction, perceived quality of care, and total cumulative cost
- An assessment of strategies for maintaining private health benefits for individuals with HIV disease and an assessment of specific business practices and regulatory barriers that could reduce access to private-sector benefits programs
- An assessment of the manner in which different points of entry to the healthcare system affect the cost, quality, and outcome of the care and treatment of individuals and families with HIV disease
- A summary report concerning the major and continuing unmet needs in healthcare, mental health, early intervention and support services for individuals and families with HIV disease, in both urban and rural areas.

Eligible grantees: Individuals and organizations with appropriate expertise in the fields of health, health policy, and economics (particularly healthcare economics).

Research and Services for Pediatric Patients With HIV

Purpose: The Health Resources and Services Administration and the National Institutes of Health shall make grants to conduct clinical research on therapies for pediatric patients with HIV disease and pregnant women with HIV, and to provide healthcare to the pediatric patients and their families.

Eligible grantees: Community health centers and other appropriate public or nonprofit private entities that provide primary care and serve a significant number of pediatric patients and pregnant women with HIV disease.

Study Regarding Partner Notification

Purpose: The Secretary of DHHS shall conduct a study of programs of HIV partner notification to determine

- In the case of individuals who have been notified under such programs, the percentage of such individuals who undergo HIV counseling and testing
- The number of such individuals having HIV disease
- The extent to which such programs have resulted in behavioral changes that are effective regarding the prevention of exposure to and transmission of HIV disease
- The extent to which such programs represent a cost-effective use of available HIV-related resources.

Study Regarding HIV Disease in Rural Areas

Purpose: The Secretary of DHHS, in consultation with the Director of the Office of Rural Health Policy, shall

- Conduct a study to estimate the incidence and prevalence in rural areas of AIDS cases and cases of infection with the etiologic agent for such syndrome
- Determine the adequacy of services for diagnosing and treating early-stage HIV infection.

Footnotes

This summary was adapted from information provided by the Bureau of Health Resources Development, Health Resources and Services Administration, Public Health Service, U.S. Department of Health. For more information about the act, including a list of State grantees, contact the office of Eric P. Goosby, M.D., Director, Division of HIV Services, 5600 Fishers Lane, Room 7A-55, Rockville, Maryland 20857; (301) 443-6745.

Appendix F—Standards of Care

Appendix F is not available in electronic format. To obtain a copy of the Standards of Care, order a hard copy of this TIP: Treatment for HIV-Infected Alcohol and Other Drug Abusers (15) by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or accessed at http://www.health. org/pubs/catalog/ordering.html. The reference number for this TIP is BKD163.

TIP 15: Appendix G—National HIV/AIDS Organizations and Hotlines

National Organizations

- AIDS Action Council
- Suite 700
- 1875 Connecticut Avenue, NW
- Washington, DC 20009
- AIDS National Interfaith Network
- 110 Maryland Avenue, NE
- Washington, DC 20002
- (202) 546-0807
- AIDS Policy Center for Children,
- Youth and Families
- 910 17th Street, NW
- Washington, DC 20036
- (202) 785-3564
- American Foundation for AIDS Research (AmFar)
- 733 3rd Avenue, 12th Floor
- New York, NY 10017

- (212) 719-0033
- Midwest Hispanic AIDS Coalition
- José Arrom
- Executive Director
- 1753 North Damen Avenue
- Chicago, IL 60647
- (312) 772-8195
- (312) 772-8484 Fax
- National Association of People With AIDS
- 1413 K Street, NW
- Washington, DC 20005
- (202) 898-0414
- National Community AIDS Partnership
- 1726 M Street, NW, Suite 501
- Washington, DC 20036
- (202) 429-2820
- National Episcopal AIDS Coalition
- Suite 509
- 2025 Pennsylvania Avenue, NW
- Washington, DC 20006
- (202) 628-6628
- National Leadership Coalition on AIDS
- 1730 M Street, NW, Suite 905
- Washington, DC 20036
- (202) 429-0930
- National Minority AIDS Council (NIAC)
- Paul Kawata
- Executive Director
- 300 I Street, NE, Suite 400

- Washington, DC 20002
- (202) 544-1076
- (202) 544-0378 Fax
- National Native American AIDS Prevention Center (NNAAPC)
- Ron Rowell
- Executive Director
- 3515 Grand Avenue, Suite 100
- Oakland, CA 94610
- (510) 444-2051
- (510) 444-1593 Fax
- National Pediatric HIV Resource Center
- 910 17th Street, NW, Suite 422
- Washington, DC 20036
- (202) 785-3509
- National Task Force on AIDS Prevention
- Randy Miller
- Executive Director
- 631 O'Farrell Street
- San Francisco, CA 94109
- (415) 749-6700
- (415) 749-6706 Fax
- National Women and HIV/AIDS Project
- P.O. Box 526-5853
- Washington, DC 20009
- (202) 526-5853

National Hotlines

AIDS Clinical Trials Information Service	800-874-2572
CDC National AIDS Hotline Spanish	800-344-7432 800-

	342-2437
HIV/AIDS Treatment Information Service	800-448-0440
National AIDS Clearinghouse (database)	800-458-5231
National Drug Abuse Hotline	800-688-1777
National Hospicelink (Information on local facilities)	800-331-1620
National Native American AIDS Hotline	800-283-2437
National Sexually Transmitted Diseases Hotline/ASHA	800-227-8922
Project Inform National Hotline (AIDS treatment information)	800-822-7422
TTY/TDD Clinical Trials Hotline	800-243-7012
The VIDEX (DDI) Reimbursement Helpline	800-788-0123

TIP 15: Appendix H—Sample Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

between

The Stimulant Treatment Outpatient Program/Opiate Treatment Outpatient Program of Substance Abuse Services, Department of Psychiatry at San Francisco General Hospital

and

The High Risk Clinic of the Maternal and Child Health Division at San Francisco General Hospital and the Bay Area Perinatal AIDS Center

The purpose of this Memorandum of Understanding is to clarify agreements between the Stimulant Treatment Outpatient Program (STOP) and the Opiate Treatment Outpatient Program (OTOP) of Substance Abuse Services (SAS), the High Risk Clinic (HRC) of the Maternal and Child Health Division, both part of San Francisco General Hospital, and the Bay Area Perinatal AIDS Center (BAPAC). These agreements form the basis of a Pilot Project, MAMATOTO: Maternal Support Program, to provide comprehensive treatment to pregnant chemically dependent patients who are identified by the High Risk Clinic or BAPAC. This MOU covers arrangements for prenatal care and substance abuse treatment. A separate MOU covers postnatal care and substance abuse services.

It is understood that a MAMATOTO: Maternal Support Program patient may qualify for and be invited to participate in BAPAC, and if accepted, the patient's medical care would be totally provided under the aegis of BAPAC. It is also understood that if the patient fails to follow BAPAC's protocol she may be asked to leave the project. In this latter case, the patient would return under the care of the High Risk Clinic. As long as the Pilot Project patient were receiving medical care either through HRC or BAPAC, and she were complying with the agreed-upon requirements for treatment at Substance Abuse Services, the patient would be maintained in MAMATOTO.

Roles and responsibilities are defined as follows:

The High Risk Clinic (HRC) and BAPAC will provide medical and psychosocial services to pregnant patients who are referred and admitted to Substance Abuse Services for treatment under the Maternal Support Program. Lisa Ryan, N.P., will be the contact person for the HRC or Wendy Kahn, M.S.W. from BAPAC.

Referral protocol:

1. The High Risk Clinic (HRC) or BAPAC will identify chemically dependent pregnant patients receiving its services who desire and are motivated to undergo substance abuse treatment for cocaine or heroin abuse. Initially, only those patients who will not need childcare services will be admitted to treatment. These "motivated" patients will be referred to STOP for stimulant dependence or to OTOP for opiate dependence.
2. The HRC or BAPAC will call a meeting of the assigned SAS counselor and the HRC or BAPAC social worker to discuss the appropriateness of the referred patient for STOP or OTOP. The SAS counselor will then meet with the patient for a motivation evaluation.
3. The HRC or BAPAC will send the patient's medical chart to STOP or OTOP for review.
4. A treatment contract will be designed for the patient so that she will know the components of treatment, i.e., the length of treatment, the expectations from HRC and BAPAC, Pediatrics, and STOP/OTOP, and the consequences for failing to comply with treatment.
5. Once selected the STOP/OTOP counselor will meet with the patient to explain MAMATOTO, the program expectations, and the contract that she is expected to sign and abide by. If the patient agrees to participate, she will sign the contract.
6. HRC or BAPAC will have the patient sign confidentiality and release-of-information forms to insure that HRC, BAPAC, OTOP/STOP, and Pediatrics share pertinent information regarding the patients in the Maternity Support Program.
7. HRC or BAPAC will ensure that the patient presents herself at STOP or OTOP for a final intake interview on the day before she is discharged from MCHD, if hospitalized, or the day before substance abuse treatment is expected to start.

8. Maternity Support Program patients will not be admitted to SAS on Fridays. If the patient is discharged on a Friday, she will have to wait to be admitted at STOP or OTOP on the following Monday.
9. While patients are in treatment at STOP/OTOP, a program liaison (Lisa Ryan, N.P., for HRC or Wendy Kahn, M.S.W., for BAPAC) will contact the assigned counselor on a weekly basis to monitor the patient's continuing participation in treatment. If there is a problem with treatment compliance or participation in STOP/OTOP, the patient's case manager at HRC or BAPAC may contact the patient as appropriate and as agreed upon with the STOP/OTOP treatment staff. If child abuse or neglect is suspected CPS will be notified.
10. The treatment contract must include centralization of the prescription of psychoactive medication to the patient in order to prevent overlapping provision of medication.
11. Copies of documentation of treatment contacts with the HRC and BAPAC will be faxed to SAS, and STOP/OTOP will, in turn, fax copies of treatment contacts to HRC and BAPAC. This sharing of documentation is critically important for SAS for it must document that prenatal care and nutritional counseling are being provided to its patients.

Required medical and psychosocial services provided by HRC and BAPAC will consist of the following:

- Prenatal visits every other week or more frequently from 2nd to 36th week, then weekly until delivery.
- Social assessments
- Health Education
- Nutrition Education
- HIV counseling (BAPAC)

- Possible limited onsite childcare by BAPAC during treatment sessions and medical appointments.
- Supplemental food and transportation
- Initial postpartum care followed by referral to GYN or Family Planning Clinic
- Family planning.

SUBSTANCE ABUSE SERVICES

OTOP will provide a maximum of three patient slots for methadone treatment for heroin abuse. STOP will provide a minimum of two patient slots. OTOP's length of treatment will be 3 months postpartum with a tapering-off period of 1 month. STOP has 4-month treatment episodes and patients may be readmitted. All Pilot Project patients will have their physical and other medical examinations and treatment carried out at HRC or BAPAC.

Intake and Admission Procedures:

1. The MAMATOTO nurse counselor for all the pregnant patients is Danyelle Perrine, R.N., P.H.N. STOP will assign a female counselor.
2. The procedures No. 2 through 11 mentioned above.
3. Before the patient is discharged, if hospitalized, or before she enters substance abuse treatment, the OTOP/STOP admissions treatment team will meet with the patient at OTOP or STOP for a final intake interview that will present the expectations for treatment and will ask the patient to sign a specific substance abuse treatment agreement.
4. In cases of medical emergency, OTOP and STOP will send the patient to the ER if she is at less than 20 weeks gestation and to Labor and Delivery if at over 20 weeks. The liaison with the prenatal provider will be notified.

OTOP will provide the following services. These services are contingent on the provision of childcare for those patients who need them:

1. Methadone dosing seven (7) days a week
2. Urinalysis once a week
3. One pregnant and postpartum women's recovery group per week
4. One other recovery group per week
5. Psychiatric care, if no other provider.

STOP will provide the following services. These services are contingent on the provision of childcare for those patients who need it:

1. Recovery groups 5 days per week. They are held in the morning (9 a.m. to 10:30 a.m.).
2. One counseling session per week
3. Urinalysis once per week.

Both parties agree to the responsibilities and procedures stated above. This agreement will be in effect/valid for through FY 92 through FY 93 and will be reviewed and/or amended every 6 months. Any changes to this MOU will be made with the approval of both parties.

In the event of termination of this MOU, each party should give or be given a 30-day notice.

TIP 15: Appendix I - Federal Resource Panel

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